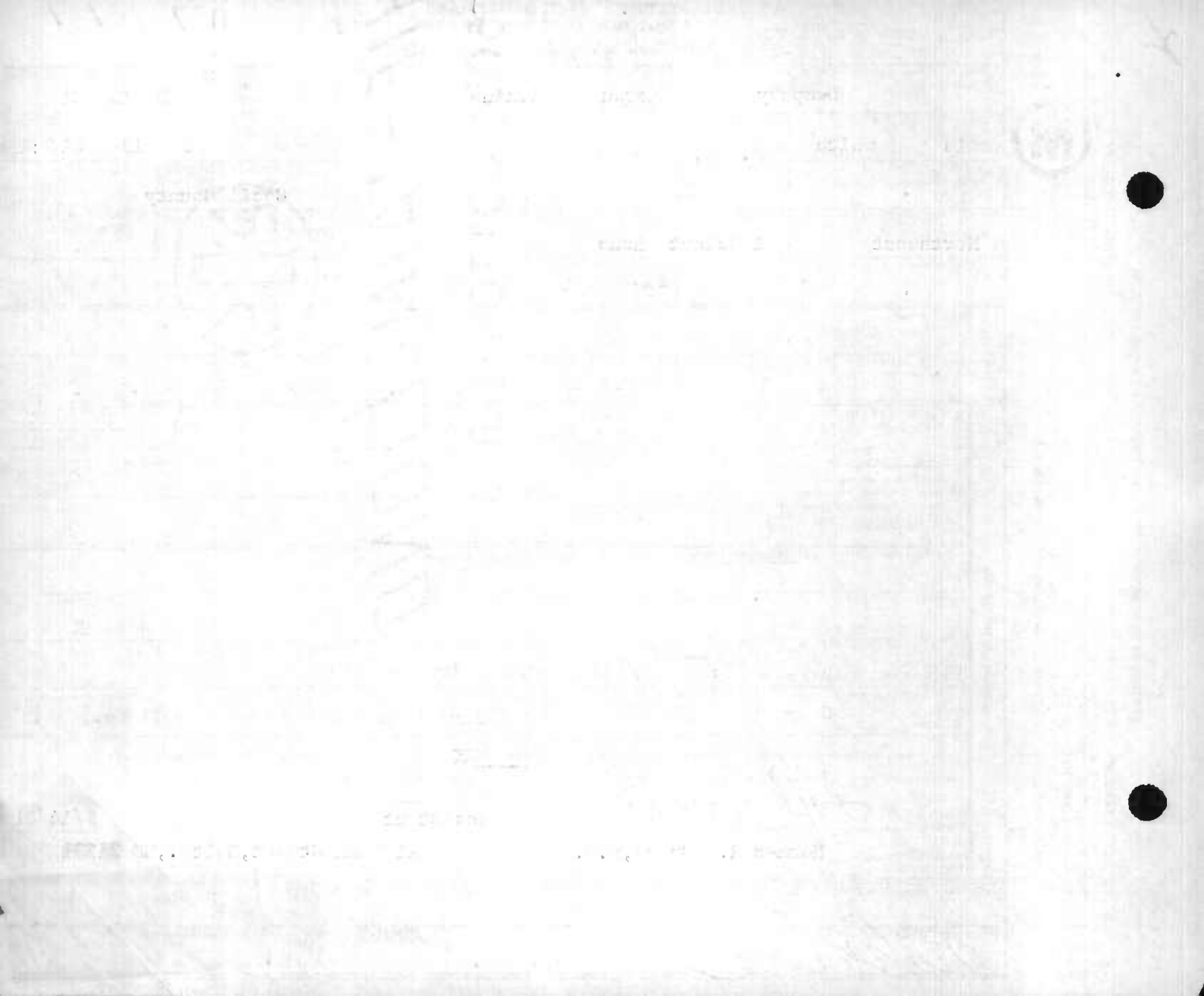


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|----------------------|--|--|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Dempsey Moran Adkins | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 3 DAY 13 YEAR 81 | |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH MONTH Mar. DAY 17 YEAR 1925 | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | IF UNDER 1 YR. MONTHS XX DAYS XX | IF UNDER 24 HRS. HOURS XX MIN. XX | 2c. DATE PRONOUNCED DEAD MONTH 3 DAY 13 YEAR 81 | | 2d. HOUR 2:15 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County | | | | | |
| 10. CITY OR TOWN OF DEATH Northeast | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1 Walnut Lane | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffer | | 12b. KIND OF BUSINESS OR INDUSTRY Govt. | | | |
| 13a. STATE Md. 13b. COUNTY Cecil 13c. CITY OR TOWN North East | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Emmerson MIDDLE Tiller LAST Tiller | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Aletha MIDDLE Adkins LAST Adkins | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. WW 11 234-34-6345 | | 17. INFORMANT Paul G. Adkins | | | | ADDRESS Elkton, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thermal injury DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) 8903 DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR 12:55 MONTH 3 DAY 13 YEAR 81 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) house trailer fire | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, EARM, ETC.) home | | 21f. LOCATION STREET 1 Walnut Lane CITY OR TOWN Northeast COUNTY Cecil Co. STATE Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE H. R. Guard | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 3/14/81 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3-17-81 | | 23c. NAME OF CEMETERY OR CREMATORY Bethel | | 23d. LOCATION CITY OR TOWN North East COUNTY Cecil STATE Md. | | | | | |
| 24. FUNERAL DIRECTOR Charles R. Guard | | | | 25a. DIRECTED BY REGISTRAR North East, Md. | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|-----------------------------------|---|---------------------------------|--|
| 1 - FOR STATE REGISTRAR | | | | | 8 1 0 7 7 7 8 | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | | |
| ESTHER L. AYERS | | | | | 03/ 30/ 81 | | | | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | | | |
| Female | | Caucasian | | 09/ 15/ 03 | | 77 | | 10:30A M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MD. | | U.S.A. | | | | Cecil Co. | | MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Elkton | | Union Hospital | | | | Oxford Cabinet Co. | | | | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | |
| Md. | | | | | Cecil | | Elkton | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| deceased Unknown | | | | | deceased Alvie Ayers | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| No | | | | | 217-01-1009 | | Old hospital records and family | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>HISTORY OF MYOCARDIAL INFARCTION</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>HISTORY OF SEVERE HYPERTENSION</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| <u>RENAL INSUFFICIENCY</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-15</u> , 19 <u>81</u> , to <u>3-5</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>3-5</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | 22b. SIGNATURE <u>E. Rahman</u> DEGREE <u>MD</u> | | | | | 22c. DATE SIGNED <u>3/30/81</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | | |
| E. RAHMAN, M.D. | | | | | 314. E. MAIN ST., NEWARK, DE 19711 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | | | 4/2/81 | | Sharps Cemetery | | Fair Hill, Maryland | | |
| 24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u> | | | | | 25a. DATE OF REGISTRATION | | 25b. REGISTRAR'S SIGNATURE | | | | |
| HICKS HOME FOR FUNERALS, ELKTON, MD. | | | | | APR 8 1981 | | | | | | |



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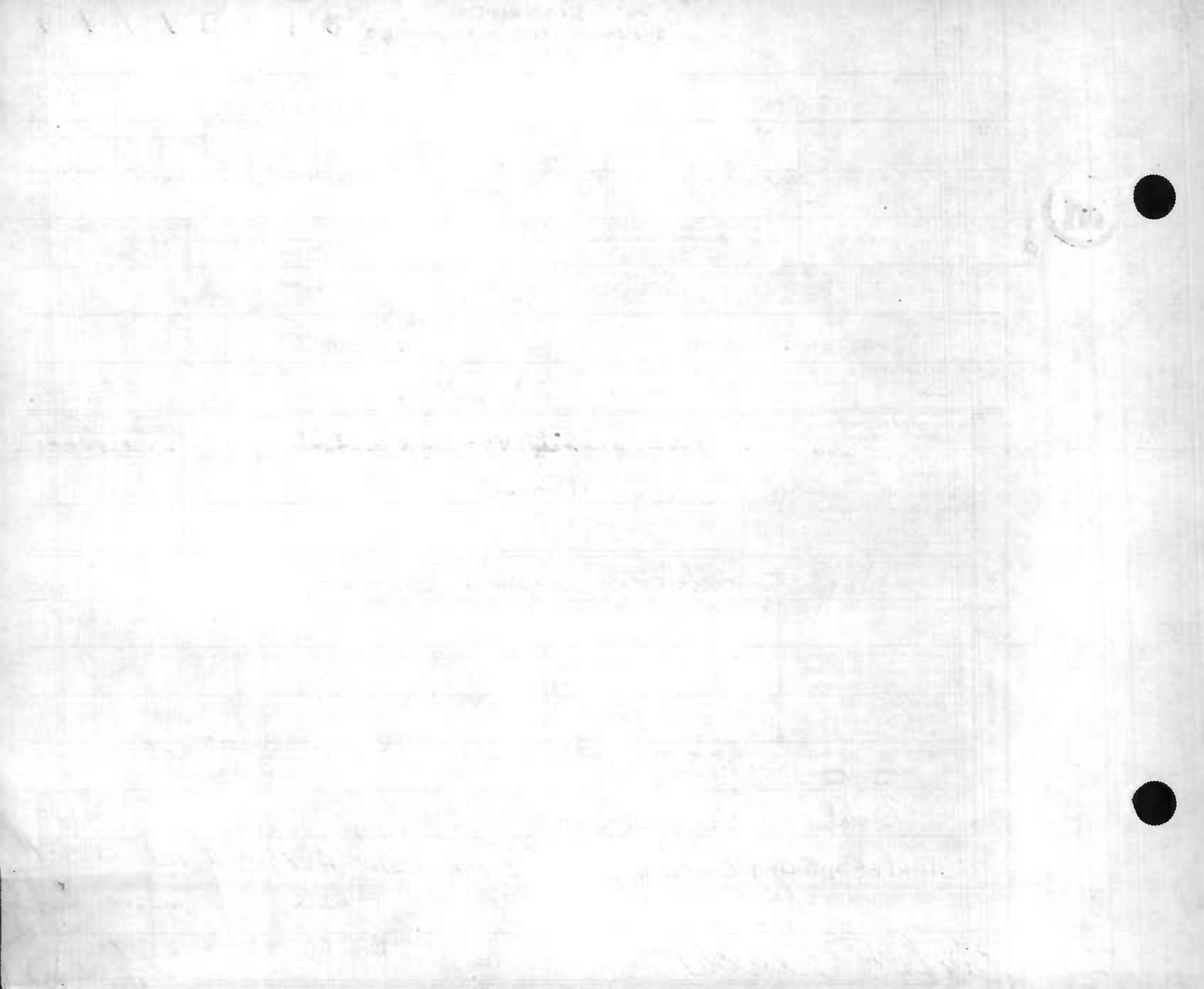
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be immediately notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|---|--|--------------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | 7 1 0 7 7 7 9 REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gladys Mae Bailey | | | | | 2a. DATE OF DEATH MONTH DAY YEAR March 22, 1981 | | | 2b. HOUR 12:15 P M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 20, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 9. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD | | | |
| 12. CITY OR TOWN OF DEATH Elkton | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher | | 15. KIND OF BUSINESS OR INDUSTRY School | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Cecil 13c. CITY OR TOWN North East | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 21 Rolls Lane | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George F. Harvey | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura E. Grant | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-34-6342 | | 17. INFORMANT ADDRESS Lucille B. Cameron North East, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Left Cerebral Vascular Accident</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 to 5 days</u> <u>years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Diabetes mellitus; Congestive Heart Failure</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 1978</u> to <u>March 22, 1981</u> , that (I) (we) lost saw the deceased alive on <u>March 22, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Charles M. Hensgen M.D.</u> | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>3/24/81</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES M. HENSGEN, M.D. | | | | 22e. ADDRESS 3 MAYLIND AVE; N.E., Md, 21901 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3-25-81 | | 23c. NAME OF CEMETERY OR CREMATORY North East Meth. | | 23d. LOCATION CITY OR TOWN COUNTY STATE North East Cecil Md. | | | |
| 24. FUNERAL DIRECTOR NAME <u>Paul A. Couch</u> | | | | ADDRESS North East, Md. | | 25a. DATE RECEIVED BY REGISTRAR MAR 30 1981 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) JOHN D. BARNES | | | 2a. DATE OF DEATH MONTH DAY YEAR March 28, 1981 | | 2b. HOUR 1:30 PM |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 5 7 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | |
| 10. CITY OR TOWN OF DEATH Perry Point | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center Perry Point, Md. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't | |
| 13a. STATE Maryland | | | 13b. COUNTY Harford | 13c. CITY OR TOWN Street | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST John D. Barnes | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary White | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW-II | | 16b. SOCIAL SECURITY NO. 214-16-6304 | 17. INFORMANT Sarah I. Barnes | | |
| | | | ADDRESS 3107 Anna Drive, Street, Md. | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Metastatic squamous cell carcinoma of**

1490

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

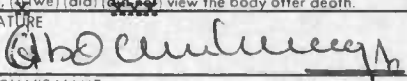
pharynx

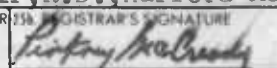
DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **110**

MEDICAL CERTIFICATION

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Mar. 25 , 19 81 , to Mar. 28 , 19 81 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Mar. 28 , 19 81 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (not) view the body after death. | | | |
| 22b. SIGNATURE  | DEGREE | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED 3-28-81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL KARIM, M.D. | | 22e. ADDRESS VAMC Perry Point, Md. | |

| | | | |
|---|--|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 2 April 81 | 23c. NAME OF CEMETERY OR CREMATORY Clarks Chapel Methodist | 23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, R.D., Harford Md. |
| 24. FUNERAL DIRECTOR NAME Kenneth S. Craig ADDRESS 21001 | 25a. DATE REC'D. BY REGISTRAR APR 3 1981 | | 25b. REGISTRAR'S SIGNATURE  |
| Tarrings Funeral Home, Aberdeen, Maryland | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1:30 p.m.

• *It*

NY Medical Center Ferry Point, N.Y.

to examine the above citation

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• 30 •

ABDUL KALIM, M. D.

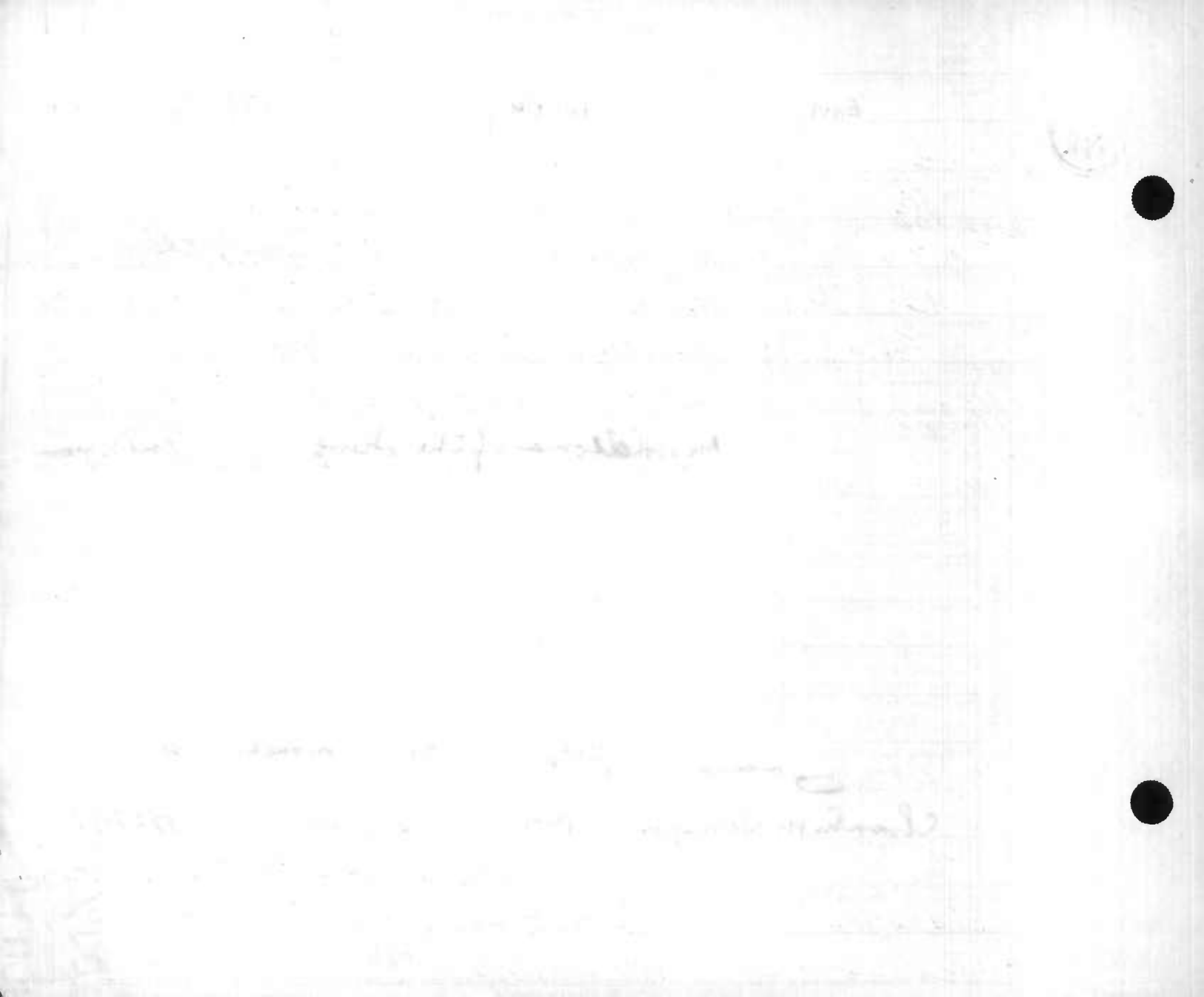
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|---|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EARL G Bentley | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 3/28/81 | | | 2b. HOUR 7:40 P.M. | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 27 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. | | 9. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | | | |
| 12. CITY OR TOWN OF DEATH Elkton | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto Mech. | | 15. KIND OF BUSINESS OR INDUSTRY Tower Co. | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md Cecil Perryville | | | | | 17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 18. STREET ADDRESS 656 Carpenters Point Rd. | | |
| 19. FATHER'S NAME FIRST MIDDLE LAST George R. Bentley | | | | | 20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carolyn Niskey | | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW II | | | | | 22. SOCIAL SECURITY NO 186-10-9560 | | 23. INFORMANT ADDRESS John E. Bentley Bolgynwyd Pg. | | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Mesothelioma of the Lung. 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 and 1/2 years | | | | | | | | | 25. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ |
| 26. DATE OF OPERATION | | | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 28. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 33. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 35. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 36. I certify that (I) (this hospital) attended the deceased from July 1975, to march 1981, that (I) (we) last saw the deceased alive on march 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 37. SIGNATURE Charles M. Hensgen MD | | | | | 38. DEGREE MD | | | 39. DATE SIGNED 3/29/81 | |
| 40. PHYSICIAN'S NAME (TYPE OR PRINT) Charles M. Hensgen | | | | | 41. ADDRESS 3 Mauldin Ave North East Md. | | | | |
| 42. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 43. DATE | | 44. NAME OF CEMETERY OR CREMATORY Cathin & Ferris | | 45. LOCATION CITY OR TOWN COUNTY STATE West Chester Chester Pa. | | |
| 46. FUNERAL DIRECTOR NAME Charles A. Roud | | | | | 47. ADDRESS North East Md. | | 48. DATE REC'D. BY REGISTRAR APR 1 1981 | | 49. REGISTRAR'S SIGNATURE [Signature] |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. 8107782 | |
|---|--|-----------|--|---|---|---|
| 1. FOR STATE REGISTRAR | | | 1 DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| | | | Belle M. Brooks | | March 18, 1981 | |
| 3 SEX | | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | |
| Female | | | Caucasian | | Jan. 12 96 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 6 AGE (IN YEARS LAST BIRTHDAY) | |
| Virginia | | | United States | | 85 YRS. | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Elkton | | | Union Hospital of Cecil County | | Housewife | |
| 13a. STATE | | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | |
| MD | | | Cecil | | 65 Fair Drive | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| Robert - Ingram | | | Jane - Davis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | |
| No | | | 217-26-2691 | | Mrs. Ruth B. Kline, Elkton, Md. 21921 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 1533 Metastases | | | | | | 10 months |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of the sigmoid colon | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| Anuria | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? |
| 12/7/80, 1/15/81 | | | Carcinoma | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | P.M. 19 | | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21c. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/4, 1980, to 3/18, 1981, that (I) (we) lost saw the deceased alive on 3/18, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED |
| Cristobal Vela, M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 3/23/81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | |
| Dr. Cristobal Vela | | | 123 West High Street, Elkton, MD 21921 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | | 3/21/81 | | Gilpin Manor Memorial Park, Elkton, Md. | | |
| 24 FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE |
| Donald S. Hicks | | | MAR 20 1981 | | | |
| HICKS HOME for FUNERALS, ELKTON, MD. | | | | | | |

BP

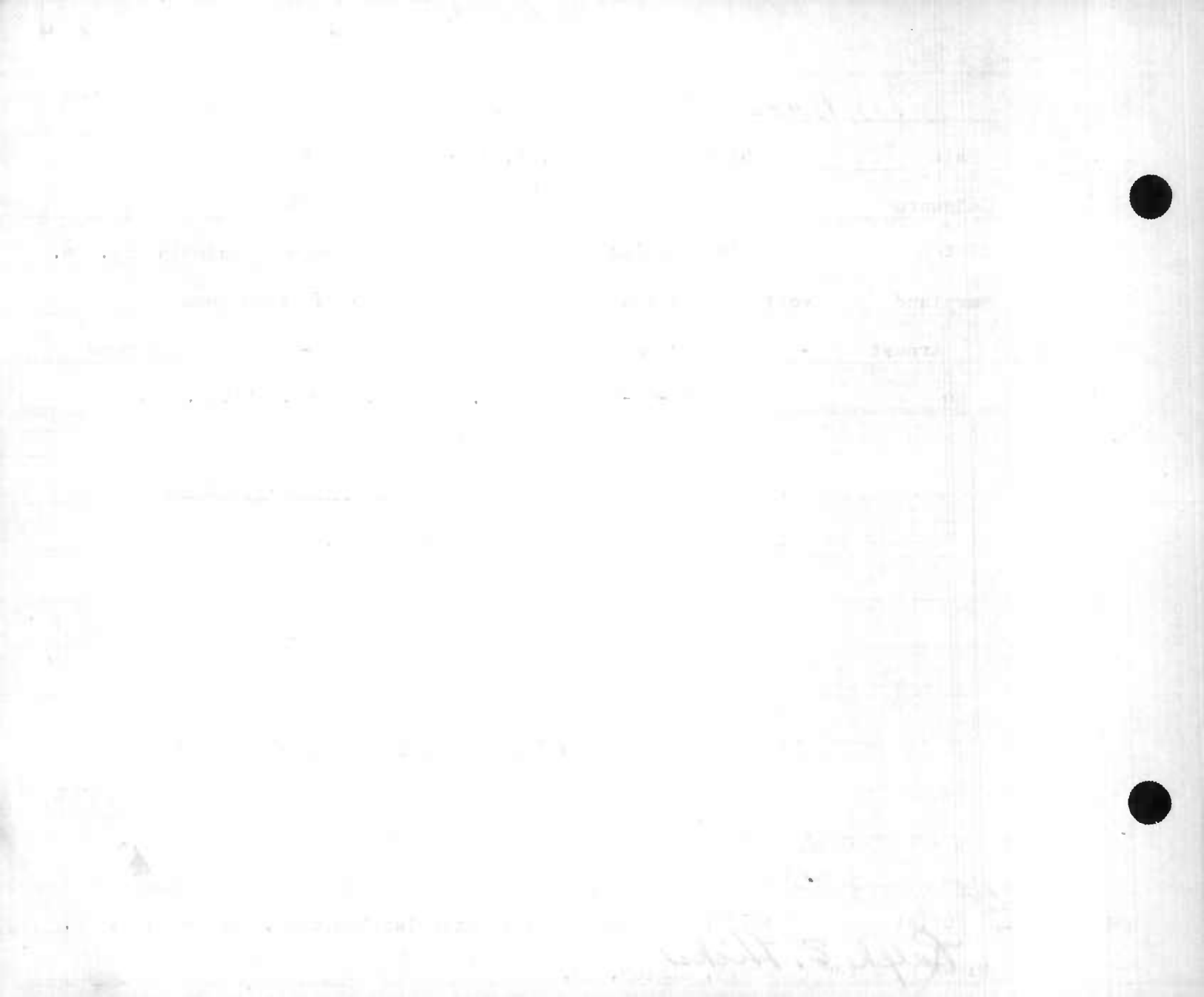
Edith E. Arnold

187851C

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 0 7 7 8 3 | | | |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Willard P Brown | | | | 2a. DATE OF DEATH 3/5/81 | | 2b. HOUR 7:30 A M | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH SEPT. 7, 1906 | | 6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | |
| 10 CITY OR TOWN OF DEATH Elkton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Weaver | | 12b KIND OF BUSINESS OR INDUSTRY Baldwin Mfg. Co. | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland | | 13b COUNTY Cecil | | 13c CITY OR TOWN Elkton | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME Ernest | | 15 MOTHER'S MAIDEN NAME Eva Drummond | | 13e STREET ADDRESS 1417 Leeds Road | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. 215-09-8880 | | 17 INFORMANT ADDRESS Mrs. Helen C. Brown, Elkton, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY Cancer Resp. Arrest 1629 IMMEDIATE CAUSE (a) Cancer DUE TO, OR AS A CONSEQUENCE OF (b) Cancer metastasized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) Prim. in lung? APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 1/11/63 to 3/5/81 , that (I) (we) last saw the deceased alive on 3/5/81 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE Joseph L. Dargatzis DEGREE MD | | | | 22c DATE SIGNED 3/5/81 | | | |
| 22b PHYSICIAN'S NAME (TYPE OR PRINT) Joseph L. Dargatzis ADDRESS Elkton, Md | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 3/7/81 | | 23c NAME OF CEMETERY OR CREMATORY Cherry Hill Methodist Cemetery, Cherry Hill, Md. | | 23d LOCATION CITY OR TOWN COUNTY STATE | |
| 24 FUNERAL DIRECTOR Ralph E. Hicks ADDRESS HICKS HOME FOR FUNERALS, ELKTON, MD. | | | | 25a DATE REC'D. BY REGISTRAR MAR 12 1981 | | 25b REGISTRAR'S SIGNATURE Anthony McCreedy | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 7 7 8 4

REG. NO.

| | | | | | | | | | | | |
|--|--|-------------------------|---|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Anna T. Byerly</i> | | | 2a. DATE OF DEATH MONTH <i>3</i> / DAY <i>13</i> / YEAR <i>81</i> | | | 2b. HOUR <i>1115</i> ^A _M | | | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Cauc.</i> | | 5. DATE OF BIRTH MONTH <i>Oct.</i> / DAY <i>29</i> / YEAR <i>1893</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>87</i> | | 7. IF UNDER 1 YEAR MONTHS <i>0</i> / DAYS <i>0</i> | | 8. IF UNDER 24 HRS HOURS <i>0</i> / MIN <i>0</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New Jersey</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> | | |
| 10. CITY OR TOWN OF DEATH <i>Elkton</i> | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital of Cecil Co.</i> | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> | | | 13c. COUNTY <i>Cecil</i> | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS <i>D Rural</i> | | |
| 14. FATHER'S NAME FIRST <i>John</i> MIDDLE <i>Trayer</i> LAST <i>Trayer</i> | | | 15. MOTHER'S MAIDEN NAME FIRST <i>Julia</i> MIDDLE <i>Drywer</i> LAST <i>Drywer</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | | 16b. SOCIAL SECURITY NO. <i>211-20-0002</i> | | | 17. INFORMANT ADDRESS <i>A John Byerly Son Box 355 Warwick</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>CHF & pleural effusion, pneumonia & dilated</i> (c) <i>H.H.D. Reticular stenosis</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2-23</i> , 19 <i>81</i> , to <i>3-13</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>3-13</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED <i>3-13-81</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Hyang W. Oh, M.D.</i> | | | 22e. ADDRESS <i>123 W. High St. Elkton, Md. 21921</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL <i>REMOVED</i> | | | 23b. DATE <i>3/17/81</i> | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Cem.</i> | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Drexel Hill Penna.</i> | | |
| 24. FUNERAL DIRECTOR NAME <i>E. Fellows and Son</i> ADDRESS <i>Millington MD 21</i> | | | 25a. DATE REC'D. BY REGISTRAR <i>MAR 20 1981</i> | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07785 | | |
|---|--|--|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Stefan Chmial NMI | | | | | | | 2a. DATE KNOWN OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 3. SEX M | | | | | | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 5 10 70 | | 6. AGE (IN YEARS) LAST BIRTHDAY 70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. | |
| 10. CITY OR TOWN OF DEATH Conowingo, Md. | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil Co. | | 12a. USUAL OCCUPATION (TYPE OF WORK) Interior Decorator | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | 13a. STATE Md. | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Conowingo | |
| 14. FATHER'S NAME FIRST MIDDLE LAST unknown | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 76 Brock Lane | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | | | | | | 16b. SOCIAL SECURITY NO. 1928-31/1932- 701-05-1010 | | 17. INFORMANT ADDRESS PerryPoint VA Hospital, Perryville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Arteriosclerotic Heart Disease IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Chronic Obstructive Lung Disease; Schizophrenia | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE Anant B. Singh | | | | | | | TITLE (SPECIFY) M.D. DEPUTY | | DATE SIGNED 3/8/81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Anant B. Singh, M.D. | | | | | | | ADDRESS Union Hospital of Cecil Co. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | 23b. DATE Mar. 10, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Colona Cecil Maryland | |
| 24. FUNERAL DIRECTOR NAME George A. Patterson & Son | | | | | | | ADDRESS Perryville, Maryland | | 25a. DATE RECEIVED BY REGISTRAR MAR 10 1981 | | 25b. REGISTRAR'S SIGNATURE | |

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3/8/81 10:12A

Stefan Gmial MWI

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x

Cecil Co.

USA.

* Poland

Gonowingo, Md. *Union Hospital of Cecil Co.

x 76 Brock Lane

Gonowingo

Cecil

Md.

unknown

unknown

yes 1928-31/1932- 701-05-1010 PerryPoint VA Hospital, Perryville, Md.

Arteriosclerotic Heart Disease

Chronic Obstructive Lung Disease: Scleroderma

x

x

xx

3/8/81

Union Hospital of Cecil Co.

Anant B. Singh, M.D.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

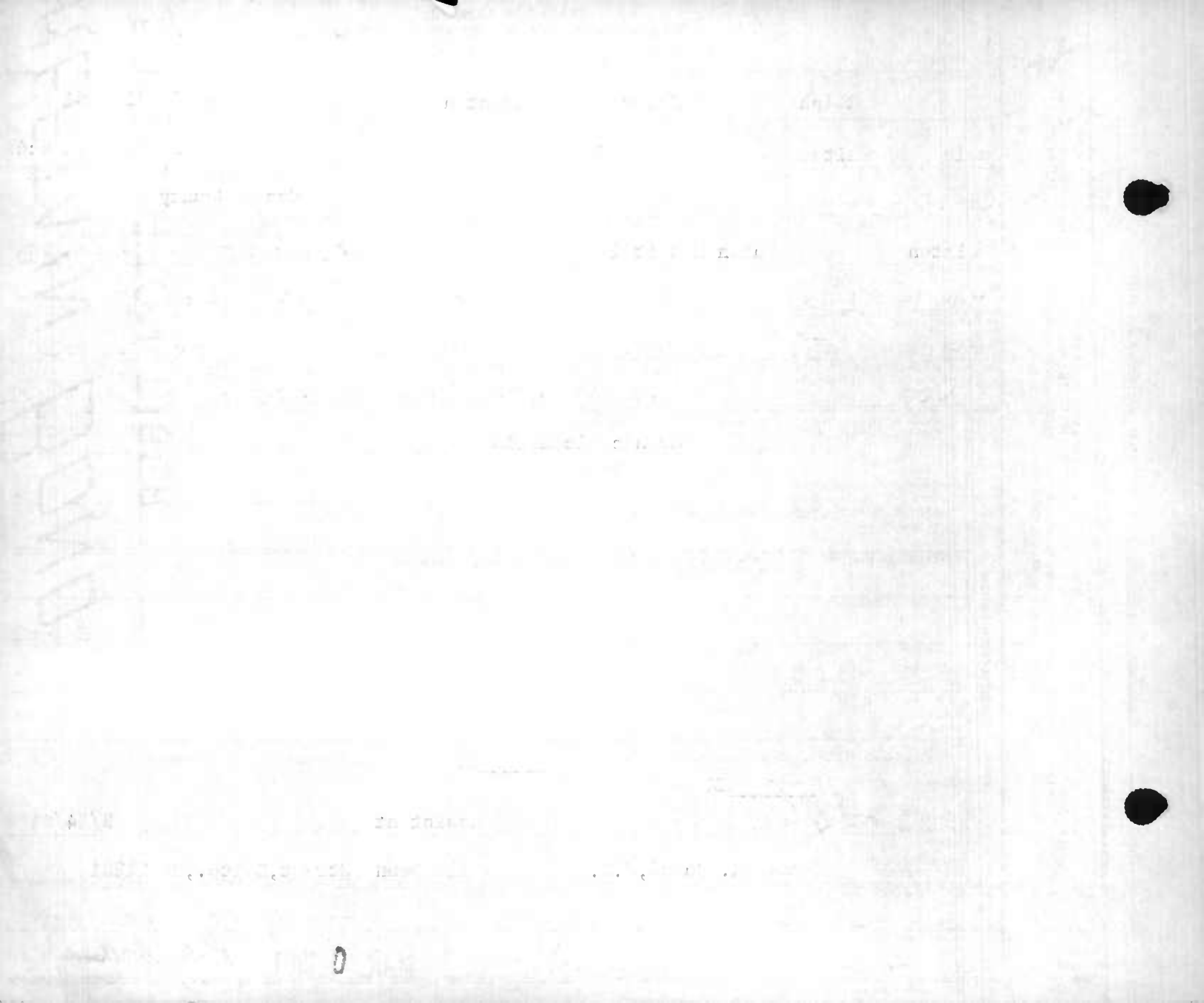
DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|---|---------|--|--|---|--|---|--|----------------------------|--|--------------------------------|--|-------|--|-----|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Ralph | | James | | Denston | | | | 3 | | 13 | | 19 | | 81 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| male | white | 2-11-38 | | 43 YRS. | | | | | | 3 | | 13 | | 19 | | 81 | | 4:45 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | PM | |
| CHESTER PA | | U.S.A. | | | | Cecil County | | | | | | | | | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Elkton | | Union Hospital | | MACHINIST | | SHIPYARD | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| MARYLAND | | CECIL | | ELKTON | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 334 MAIN ST | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| Ralph | | J. DENSTON SR. | | MARGARET | | BROWNING | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| NO | | 162-28-4502 | | ISABELLE DENSTON | | CLAYMONT DEL | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic alcoholism</u> 3030 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | TITLE (SPECIFY) Assistant | | DATE SIGNED | | 3/14/81 | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| Hormez R. Guard, M.D. | | 111 Penn Street, Balto., MD 21201 | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| BURIAL | | 3-16-81 | | ST. Stephen's | | EARLEVILLE CECIL MD | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| EDW. Fellows & SON | | 21651 MILLINGTON MD | | MAR 20 1981 | | History & Records | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8107737 | |
|--|--|---|--|---|--|--|--|--|------------------------------------|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clifton Johnson Dixon | | | | 2a. DATE OF DEATH MONTH DAY YEAR March 14, 1981 | | | | 2b. HOUR 5:50AM | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR May 12, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS 65 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Perry Point | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center, Perry Point, Md | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY None | | | |
| 13a. STATE D.C. | | | | 13b. COUNTY N/A | | 13c. CITY OR TOWN Washington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1201 Rhode Is. Ave. N.W. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alexander Johnson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Williams | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> WW II | | | | 16b. SOCIAL SECURITY NO. 577 18 3160 | | 17. INFORMANT ADDRESS Elsworth Williams-1362 Spring Rd. N.W. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 1619 DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Larynx with Metastases | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from December 9, 1980 to March 14, 1981 XXXXXXXX above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE DEGREE P. Jacques Jean-Pierre MD | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 3-14-81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. Jacques Jean-Pierre | | | | | | 22e. ADDRESS VA Medical Center, Perry Point, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 3-20-81 | | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cem., Suitland, Md. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME Henry S. Washington & Son | | | | 4925 Dean Ave., NE Washington, DC | | 25a. DATE REC'D. BY REGISTRAR 3-18-81 | | 25b. REGISTRAR'S SIGNATURE | | | |

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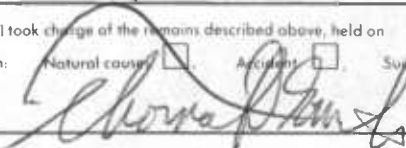

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07788 | |
|--|-------------------------|---|--|---|---|--|---|---|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Patricia Dotson | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 3 DAY 20 YEAR 1981 | | 2b. HOUR M | | | |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH MAY DAY 7 YEAR 1953 | 6. AGE (IN YEARS LAST BIRTHDAY) 27 YRS. | IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN. | 7c. DATE PRONOUNCED DEAD MONTH 3 DAY 20 YEAR 1981 | 2d. HOUR 7:30 P | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH North East | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lums Road - in woods | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OFFICE WORKER | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE NEW YORK 13b. COUNTY QUEENS 13c. CITY OR TOWN JAMAICA | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 107-39 159TH ST. 11433 | | | | | |
| 14. FATHER'S NAME FIRST JOSEPH MIDDLE HARRIS LAST HARRIS | | | | 15. MOTHER'S MAIDEN NAME FIRST MARIE MIDDLE KIRKLAND LAST KIRKLAND | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT (MOTHER) ADDRESS MRS. MARIE HARRIS SAME AS #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab wounds of chest and strangulation 9660 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR 5:30 AM 3 MONTH 20 YEAR 1981 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject assaulted | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) woods | | 21f. LOCATION STREET Lums Rd. CITY OR TOWN North East, COUNTY Cecil STATE MD. | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | TITLE (SPECIFY) M.D. Deputy Chief | | | MEDICAL EXAMINER | | | DATE SIGNED 3/21/81 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | ADDRESS 111 Penn St. | | | BALTO., MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 3/27/81 | | 23c. NAME OF CEMETERY OR CREMATORY ROCKVILLE CEMETERY | | | 23d. LOCATION CITY OR TOWN LYNDBROOK COUNTY NASSAU STATE N.Y. | | | | |
| 24. FUNERAL DIRECTOR NAME E. BARNES ADDRESS 21018 FLEMING FUNERAL SERVICE BENSON, MD | | | 25a. DATE REC'D. BY REGISTRAR MAR 24 1981 | | 25b. REGISTRAR'S SIGNATURE  | | | | | | |

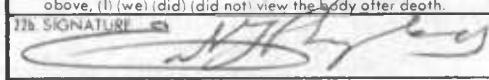
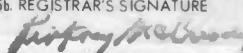


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 07/89 | | | |
|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Clifford R Durham | | | | 2a. DATE OF DEATH MONTH DAY YEAR 03/05/81 | | | | 2b. HOUR 9:15A | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 02 04 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Elkton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Guard- Triumph Explosives Co. | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN North East | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 505 Mechanics Valley Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 218-09-9053 | | 17. INFORMANT Mrs. Hazel Morris, North East, Md. | | | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Failure 4960 DUE TO, OR AS A CONSEQUENCE OF (b) COPD + Myo. Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March , 19 73 , to March 5 , 19 81 , that (I) (we) lost saw the deceased alive on Feb. 22 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE  | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED March 5/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ernesto M. Ablang, M.D. | | | | 22e. ADDRESS 200 Bow Street, Elkton, Maryland 21921 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3/9/81 | | 23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Elkton, Maryland 21921 | | | | | |
| 24. FUNERAL DIRECTOR HACKS HOME FOR FUNERALS, ELKTON, MD. | | | | 25a. DATE REC'D. BY REGISTRAR MAR 12 1981 | | 25b. REGISTRAR'S SIGNATURE  | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 7 7 9 0

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|--|--|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) <u>AMANDA S. Ellis</u> | | | 2a DATE OF DEATH MONTH <u>3</u> DAY <u>29</u> YEAR <u>81</u> | | 2b HOUR <u>1030</u> <u>A</u> |
| 3 SEX <u>Female</u> | 4 RACE <u>White</u> | 5 DATE OF BIRTH MONTH <u>March</u> DAY <u>21</u> YEAR <u>1902</u> | 6 AGE (IN YEARS LAST BIRTHDAY) <u>79</u> YRS. | 7b HOUR <u>1030</u> <u>A</u> | |
| 8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Roxboro, Pa.</u> | 8b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | 9 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>Cecil</u> MD. | | |
| 10 CITY OR TOWN OF DEATH <u>Elkton</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Union Hospital</u> | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u> | 12b KIND OF BUSINESS OR INDUSTRY <u>at home</u> | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <u>Md.</u> 13b CITY <u>Cecil</u> 13c CITY OR TOWN <u>Elkton</u> | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS <u>Rte. 4 Red Hill Road</u> | |
| 14 FATHER'S NAME FIRST <u>Harold</u> MIDDLE <u>Wileman</u> LAST <u>Wileman</u> | | | 15 MOTHER'S MAIDEN NAME FIRST <u>Mary</u> MIDDLE <u>Mculla</u> LAST <u>Mculla</u> | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u> | | 16b SOCIAL SECURITY NO <u>216-12-7178</u> | 17 INFORMANT ADDRESS <u>Lois M. Murphy 76 Hollingsworth Manor Elkton, Md.</u> | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4049 Congestive heart failure and</u> DUE TO, OR AS A CONSEQUENCE OF <u>pneumonia</u> (b) <u>Arteriosclerotic cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF <u>renal disease</u> (c) <u>Severe anemia</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>over 1 yr.</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Severe anemia</u> | | | | | |
| 19a DATE OF OPERATION <u>March 29 1981</u> | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Severe anemia</u> | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>March 29 1981</u> to <u>March 29 1981</u> , that (I) (we) lost saw the deceased alive on <u>March 29 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE <u>S. Ralph Andrews</u> | | DEGREE <u>M.D.</u> | | 22c DATE SIGNED <u>3/30/81</u> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. Ralph Andrews, M.D.</u> | | 22e ADDRESS <u>233 E. Main St., Elkton, Md. 21921</u> | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b DATE <u>April 1, 1981</u> | 23c NAME OF CEMETERY OR CREMATORY <u>Rose Bank Cemetery</u> | | 23d LOCATION CITY OR TOWN <u>Calvert</u> COUNTY <u>Cecil</u> STATE <u>Md.</u> |
| 24 FUNERAL DIRECTOR NAME <u>SEE FUNERAL HOME</u> ADDRESS <u>Elkton, Md.</u> | | 25a DATE REC'D. BY REGISTRAR <u>3/30/81</u> 25b REGISTRAR'S SIGNATURE | | | |

BP

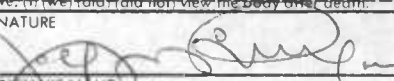
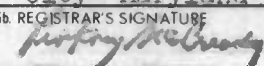


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Charles Edward Guthrie | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR March 15, 1981 | | | 2b. HOUR 12:05A_M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 6 8 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD | | | | | |
| 10. CITY OR TOWN OF DEATH Perry Point | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center, Perry Point, Md | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Super. U.S. Gov't | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Aberdeen | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 25 Rigdon Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Guthrie | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Polly Sweeney | | | | ADDRESS Freeland, Maryland 21053 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW-II/Korea 212 36 0036 | | 17. INFORMANT Edmund F. Ledvinka, Jr., 2 W. Cores Mill Road, | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4254 Cardio Respiratory Arrest | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cardio Myopathy | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 11, 19 81 to March 15, 19 81 XXXXXXXX | | | | | | | | | | | |
| 22b. SIGNATURE  DEGREE no | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 3-15-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. Jacques Jean-Pierre | | | | | | 22e. ADDRESS VA Medical Center, Perry Point, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 3/19/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME Tarring Funeral Home | | | | | | ADDRESS Aberdeen, Md | | 25a. DATE REC'D. BY REGISTRAR MAR 18 1981 | | 25b. REGISTRAR'S SIGNATURE  | |

March 12, 1981 12:00 PM

to the office of the
Director of the
VA Medical Center, Fort Belvoir

Re: [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

Enclosed for the Director are two copies of a letterhead memorandum (LHM) dated and captioned as above. The LHM is being furnished to you for your information and for your review and comment.

Very truly yours,
[illegible]
[illegible]

March 12, 1981

1-1-81

VA Medical Center, Fort Belvoir
[illegible] [illegible] [illegible]

Enclosed for the Director are two copies of a letterhead memorandum (LHM) dated and captioned as above. The LHM is being furnished to you for your information and for your review and comment.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 7 1 9 2 | |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) ARTHUR J. HUDDLE SR | | | | 2a. DATE OF DEATH MONTH 3 DAY 13 YEAR 81 | |
| 3. SEX MALE | | 4. RACE WHITE | | 2b. HOUR 5:13 AM | |
| 5. DATE OF BIRTH MONTH 2 DAY 2 YEAR 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEAR) SEC. GUARD | |
| 10. CITY OR TOWN OF DEATH ELKTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSPITAL | | 12b. KIND OF BUSINESS OR INDUSTRY D.P.+L. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE DELAWARE 13c. COUNTY N.C. | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST JOSEPH MIDDLE H LAST HUDDLE | | | | 15. MOTHER'S MAIDEN NAME FIRST EMMA MIDDLE C LAST CAMPBELL | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 221-01-1775 | | 17. INFORMANT ADDRESS MARY HUDDLE - TOWNSEND, Del. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 8/12 , 19 81 , to 3/13 , 19 81 , that (1) (we) lost saw the deceased alive on 3/13 , 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Kenneth Lewis, MD DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 3/13/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH LEWIS, MD | | | | 22e. ADDRESS 12 PENNINGTON ST, MIDDLETOWN, Del. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Mar 15, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY St. James Cem. | |
| 23d. LOCATION NEAPORTON, N.C. | | 23e. COUNTY Del. | | 23f. STATE Del. | |
| 24. FUNERAL DIRECTOR NAME PROFIT C. Hutton - Middletown, Del. ADDRESS Middletown, Del. | | | | 25a. DATE REC'D. BY REGISTRAR MAR 19 1981 | |
| 25b. REGISTRAR'S SIGNATURE | | | | 25c. REGISTRAR'S SIGNATURE | |

BP

10-1-51

Hobbs, J.

Arthur

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP _____

DHMM-16 20M
(VRA 15, 4) 7/78

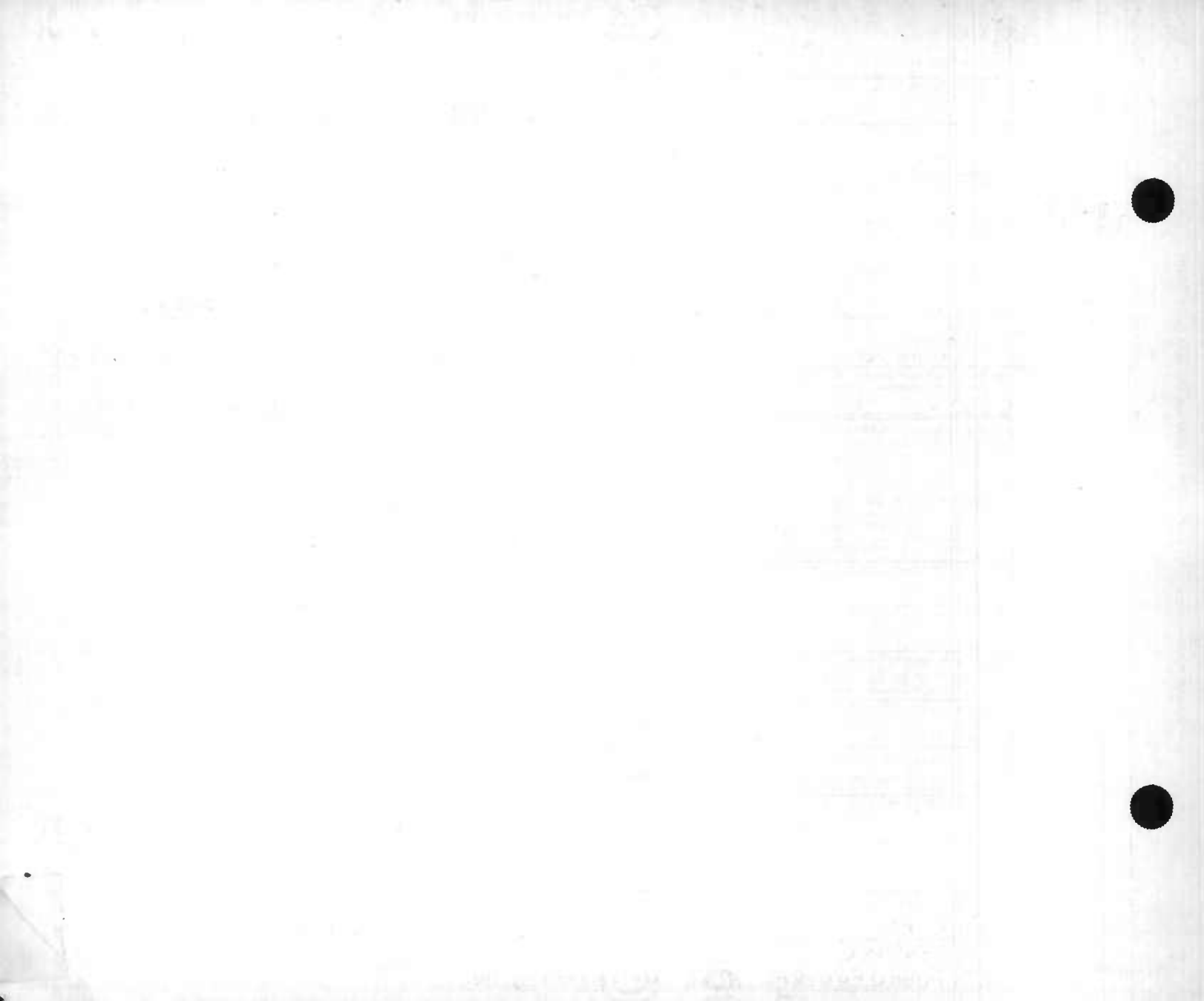
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 0 7 7 9 3

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Viola M. Johnson | | | 2a. DATE OF DEATH MONTH DAY YEAR 3 24 81 | | | 2b. HOUR 5 ³⁰ A.M. | | | | |
| 3 SEX Fe | | 4 RACE Cauc. | | 5 DATE OF BIRTH MONTH DAY YEAR 7 22 04 | | 6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. MD. | | | | |
| 10 CITY OR TOWN OF DEATH Elkton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Laurelwood Nursing Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Personal Supr. | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Elkton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 33 Park Lane | |
| 14 FATHER'S NAME FIRST MIDDLE LAST GEORGE Boulden | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sue Boulden | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 221-16-6755 | | 17 INFORMANT George B. Johnson | | ADDRESS 33 Park Lane Elkton, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CVA - left hemiplegia H.H.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Extensive diverticulosis, anxiety depression</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-12</u> 19 <u>80</u> , to <u>3-24</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>3-22</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 3-24-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hyung W. Oh, M.D. | | | 22e. ADDRESS 123 W. High, Elkton, Md. 21921 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 3-27-81 | | 23c. NAME OF CEMETERY OR CREMATORY SILVERBROOK Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE W.L.M. N.C. De. | | | |
| 24 FUNERAL DIRECTOR R.T. FORD FUNERAL HOME, CHESAPEAKE, VA. | | | | | | 25a. DATE REC'D. BY REGISTRAR MAR 30 1981 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

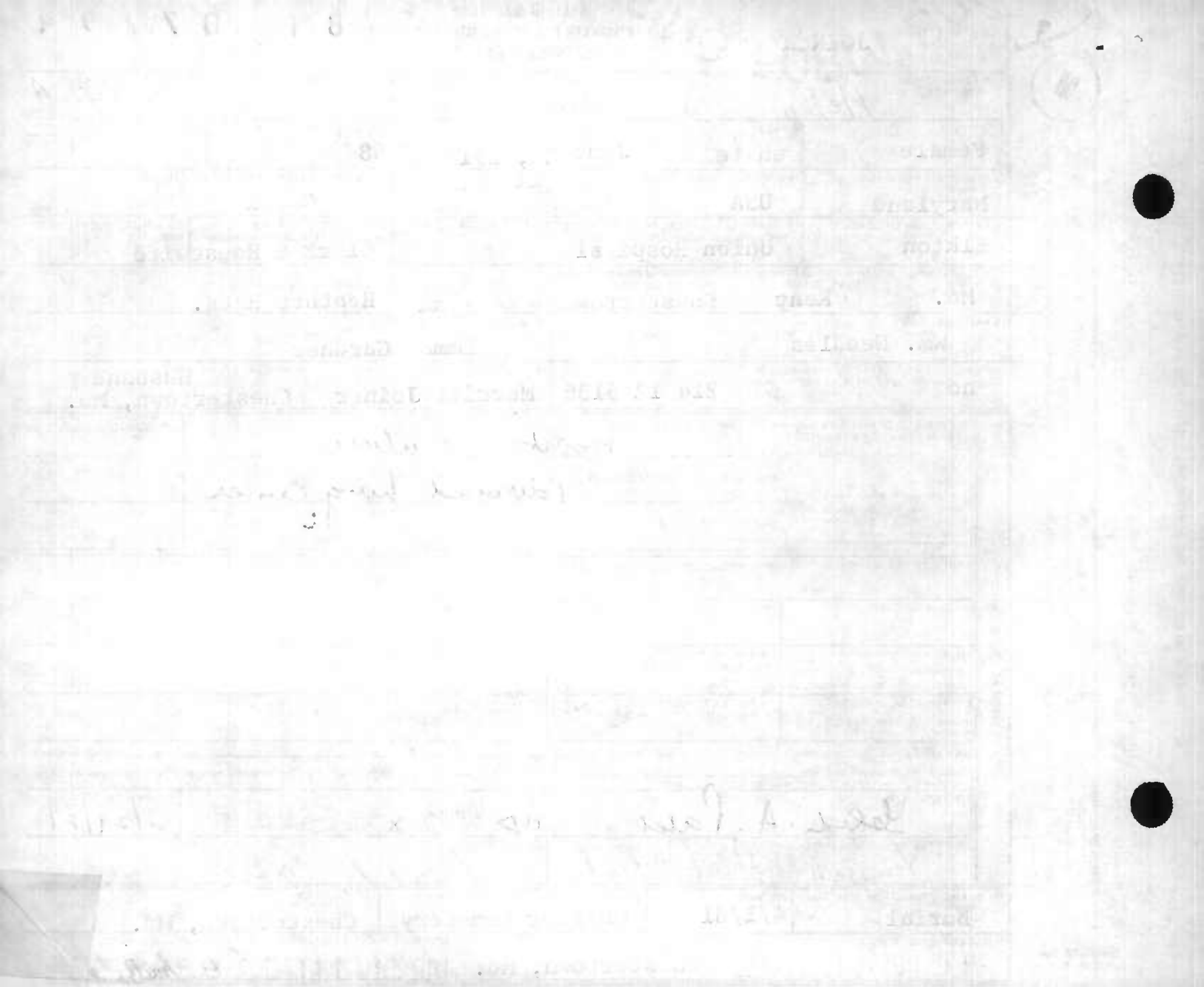
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 7 7 9 4 | |
|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | JOINER | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | REG. NO. | |
| 2a DATE OF DEATH | | | | 2b HOUR | |
| 3 SEX | | | | 4 RACE | |
| 5 DATE OF BIRTH | | | | 6 AGE (IN YEARS LAST BIRTHDAY) | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b CITIZEN OF WHAT COUNTRY? | |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| 10 CITY OR TOWN OF DEATH | | | | 11a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 11b NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE | | | | 13b STREET ADDRESS | |
| 14 FATHER'S NAME | | | | 15 MOTHER'S MAIDEN NAME | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b SOCIAL SECURITY NO. | |
| 17 INFORMANT | | | | ADDRESS | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED | | 21a PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i LOCATION | |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b SIGNATURE | | 22c DATE SIGNED | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | 22f REGISTRAR'S SIGNATURE | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | |
| 23d LOCATION CITY OR TOWN | | 23e COUNTY | | 23f STATE | |
| 24 FUNERAL DIRECTOR NAME | | 24b ADDRESS | | 24c DATE REC'D. BY REGISTRAR | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|--|---|---|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) IDA M. KELLEY | | | 2a. DATE OF DEATH MONTH DAY YEAR 3/29/81 | | | 2b. HOUR 4:52 P.M. | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9 19 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | | | | |
| 10. CITY OR TOWN OF DEATH ELKTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSPITAL of Cecil County | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN ELKTON | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 42 Blossom Lane | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George - McConhay | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy May Draper | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO 213-74-9233 | | 17. INFORMANT ADDRESS Mr. George E. Kelley, Elkton, Md. 21921 | | | | | |

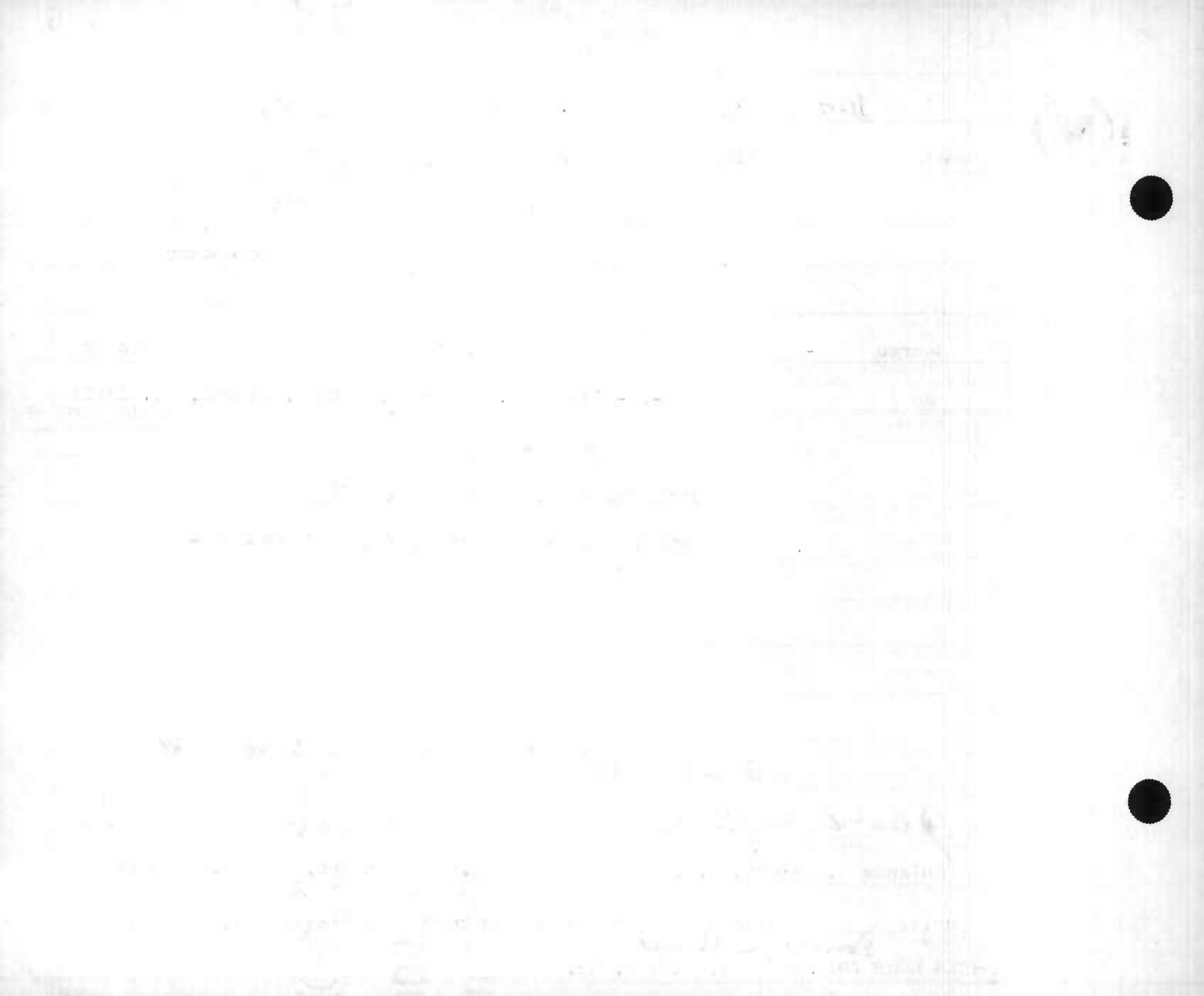
| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPTICEMIA 2041 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) BACTERIAL MENINGITIS DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC LYMPHOCYTIC LEUKEMIA | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|---|--|--|--|

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-28 , 19 81 , to 3-29 , 19 81 , that (I) (we) last saw the deceased alive on 3-29 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Rolando A. Najera | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 3/29/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rolando A. Najera, M.D. | | | | 22e. ADDRESS 105 E. Main Street, Elkton, Maryland | | | |

| | | | | | | | |
|--|--|----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 4/2/81 | | 23c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rising Sun, Maryland | |
| 24. FUNERAL DIRECTOR NAME Donald A. Hicks ADDRESS HICKS HOME for FUNERALS, ELKTON, MD. | | | | 25. DE REGD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 6 1981 | | | |

BP

DHMH-16 20M
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 381-1234.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) GEORGE B. KENNEDY | | | | | 2a. DATE OF DEATH MONTH DAY YEAR March 1, 1981 | | | 2b. HOUR 3:55pm | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 13, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH XXXXXXXXXX Perry Point, Cecil | | | |
| 10. CITY OR TOWN OF DEATH Perry Point | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printing executive | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland 13b. COUNTY Mont. 13c. CITY OR TOWN Takoma Pk. | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 7715 Takoma Ave. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William T. Kennedy | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie F. Boutell | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. WW1 | | 17. INFORMANT 4202 Garrison St. N.W. Wash. DC | | Mrs. June Scopeletis | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral 4140 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic coronary artery disease | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 14 , 19 77 , to March 1 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE S. Goldgraben DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED 3-3-81 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. GOLDGRABEN, M.D. | | | | | 22e. ADDRESS VAMC, Perry Point, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Mar. 5, 1981 | | 23c. NAME OF CEMETERY OR CREMATOR Fort Lincoln | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bladensburg, Md. | | | |
| 24. FUNERAL DIRECTOR 4748 Wisc. Ave. TaltaZull Funeral Home, Washington, DC | | | | | 25a. DATE REC'D. BY REGISTRAR MAR 6 1981 | | 25b. REGISTRAR'S SIGNATURE Harvey M. Harvey | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 7 7 9 7 | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| WILLIAM G. KOLDUS | | | | March 19, 1981 | | | | 1:50a _M | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| XX | | W | | 10 8 33 | | 47 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| GA | | U.S.A. | | | | CECIL MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| PERRYVILLE | | VA Medical Center Perry Point, Md. | | | | | | RET STORE OWNER | | FOOD | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| MD | | | | CECIL | | RISING SUN | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 35 LAFALETTE AVE | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| ANDRUS KOLDUS | | | | LORRAINE WARD | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| YES | | | | KOREAN | | MARY P. KOLDUS | | RISING SUN MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) PNEUMONITIS | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) PLEURAL EFFUSION, RIGHT LUNG | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) CARCINOMA OF RIGHT LUNG | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| METASTATIC DISEASE, H.O. HYPERURICEMIA | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (x) (this hospital) attended the deceased from Feb. 24, 19 81, to Mar. 19, 19 81, that (we) lost saw the deceased alive on Mar 19, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (do not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| Glendon E. Rayson | | | | | | | | 3-18-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| GLEDON RAYSON, M.D. | | | | VAMC Perry Point, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| BURIAL | | | | 3-21-81 | | CALVARY BAPTIST | | RISING SUN CECIL MD | | | |
| 24. FUNERAL DIRECTOR'S NAME | | | | ADDRESS | | | | 25. DATE RECEIVED BY REGISTRAR | | | |
| FOARD FUNERAL HOME, Rising Sun, Md. | | | | | | | | MAR 20 1981 | | | |

• FORWARD THE FOLLOWING INFORMATION TO THE

GLENNON, HAYSON, A.D.

WAGG, Perry Point, Md.

1-18-61

X

Mar 19

81

X

Feb. 19

81

Mar. 19

81

X

STATISTICAL DISCARD, H.O. HYPERBOLICITY

CARDIOMY OF RIGHT LUNG

PLEURAL EFFUSION, RIGHT LUNG

PNEUMONITIS

122-48-4222

VA Medical Center, Perry Point, Md.

WILLIAM

C.

240002

March 19, 1961

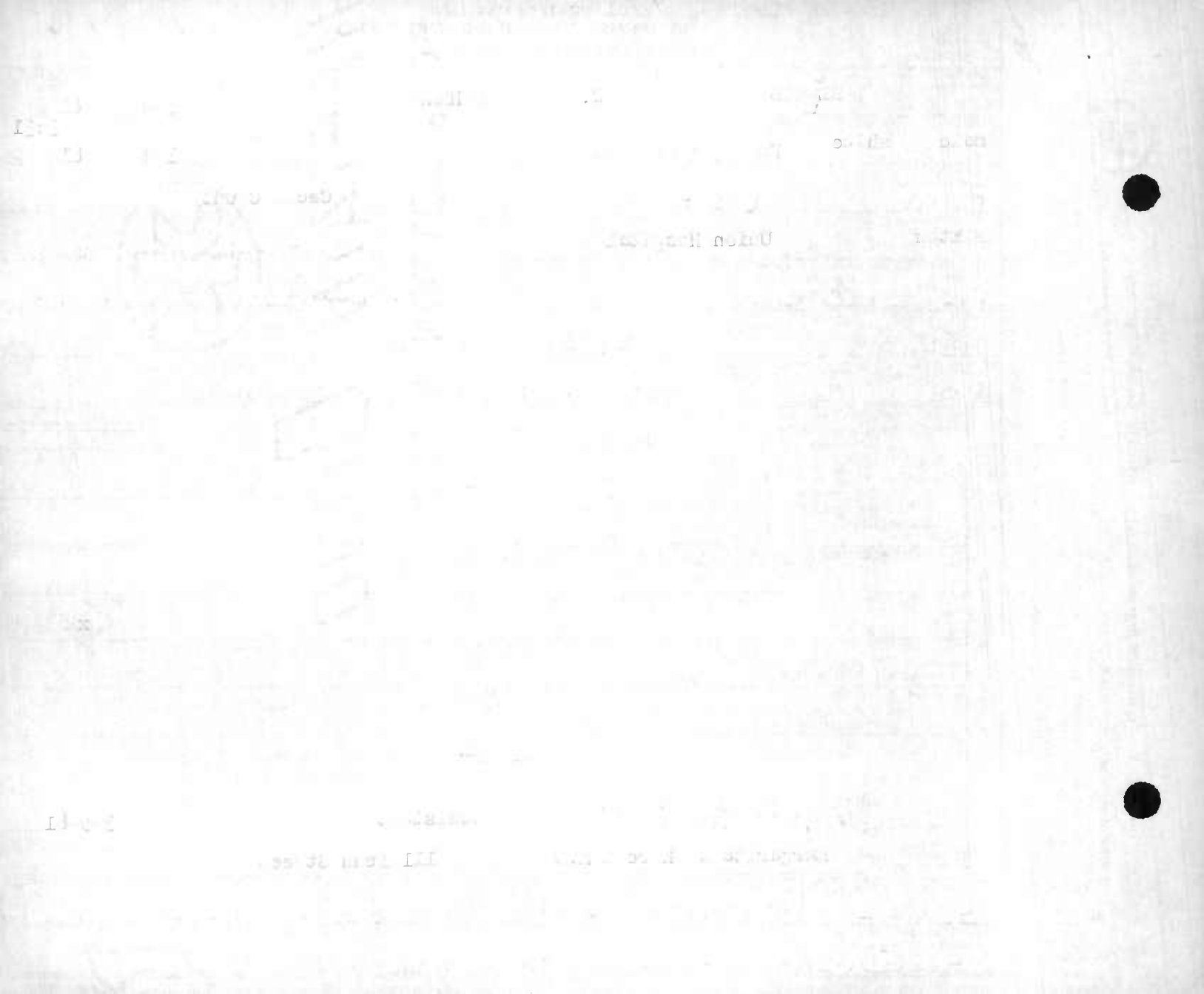
1:204

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
15M 2/80

| Items #18a-22a Film G554 4/2/81 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07798 | | | | | | | |
|--|--|--------------------------|--|--|--|--|--|---|--|--|--|--|--|---|--|--|--|
| 1- STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) ELWOOD C. LEHMAN | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 3-4 19 81 | | 2b. HOUR 3:31 PM | | | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH (MONTH DAY YEAR) Nov. 30 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 3-4- 19 81 | | 3d. TIME PM | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County | | | | | |
| 10. CITY OR TOWN OF DEATH Elkton | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Union Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GLEN F. GALL, Co. LUMBER | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS BOX 263 WEST REOHILL RD. | | | |
| 13a. STATE MD. | | 13b. COUNTY CECIL | | 13c. CITY OR TOWN | | 14. FATHER'S NAME (FIRST MIDDLE LAST) William LEHMAN | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) DORA STEIN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 215 302772 | | | | 17. INFORMANT ADDRESS FAMILY RECORDS | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alcoholism 3030 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A Korell | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 3-5-81 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 3-7-1981 | | 23c. NAME OF CEMETERY OR CREMATORY BELAIR MEM. GARDEN | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BELAIR HARBOR MD. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME EVANS FUNERAL CHAPEL | | | | ADDRESS 8800 HARFORD RD | | | | 25a. DATE REC'D. BY REGISTRAR 3-13-1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | |

MEDICAL CERTIFICATION



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

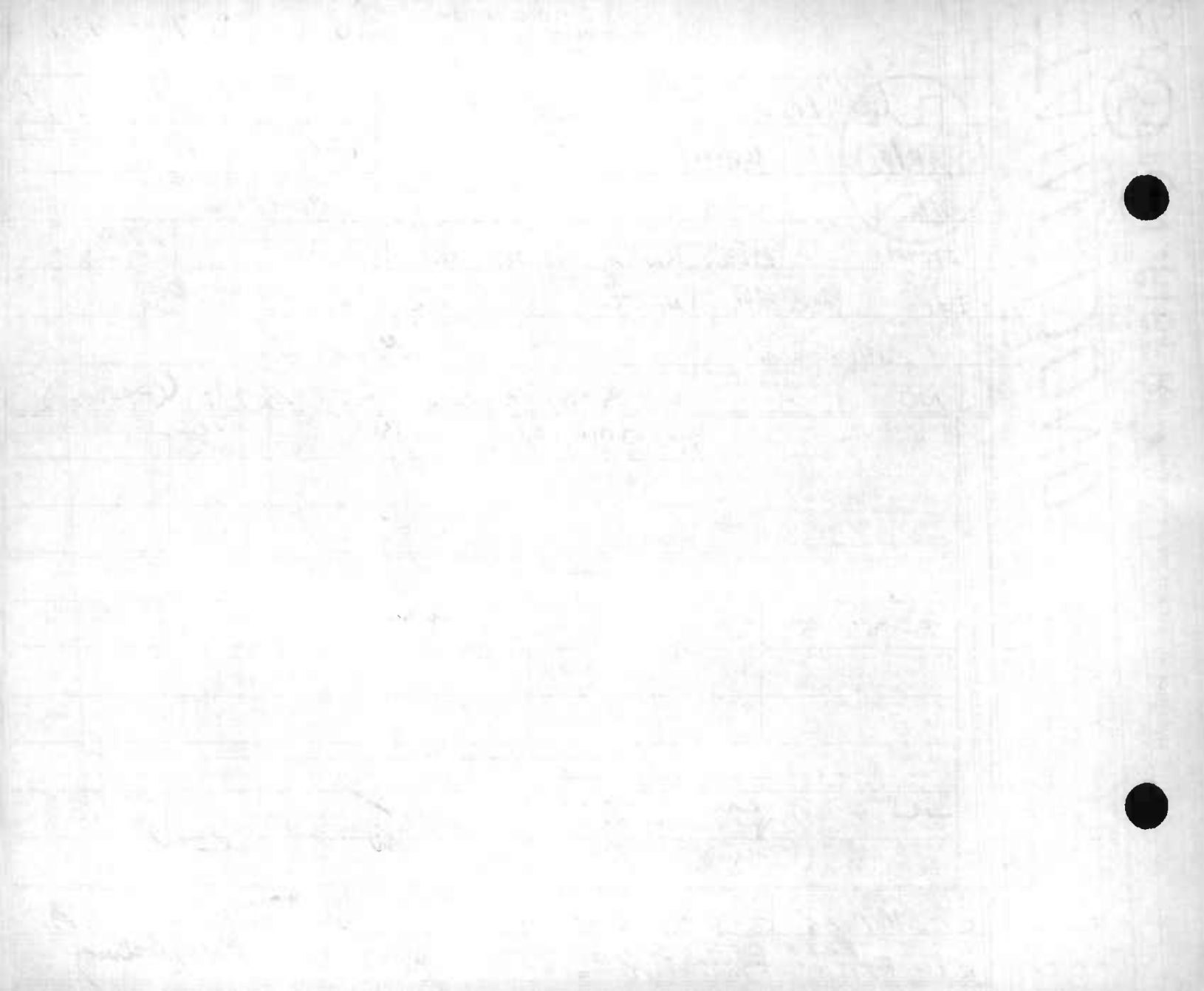
| | | | | | | | | | | |
|---|--|---|---|--|--|--|---|---|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) William R Leist | | | 2a DATE OF DEATH MONTH 3 DAY 29 YEAR 81 | | | 7b HOUR 210 P.M. | | | | |
| 3 SEX MALE | | 4 RACE White | | 5 DATE OF BIRTH MONTH 6 DAY 21 YEAR 19 | | 6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLA. | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | | | | |
| 10 CITY OR TOWN OF DEATH ELKTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ELKTON UNION, ELKTON MD. | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COOK. | | 12b KIND OF BUSINESS OR INDUSTRY FOOD | | |
| 13a STATE Del | | | 13b COUNTY NEWCASTLE | | 13c CITY OR TOWN NEWARK | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS 80 REGION DR. | |
| 14 FATHER'S NAME FIRST UNKNOWN MIDDLE UNKNOWN LAST UNKNOWN | | | 15 MOTHER'S MAIDEN NAME FIRST UNKNOWN MIDDLE UNKNOWN LAST UNKNOWN | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - | | 17 INFORMANT NORMA J. LEIST (SAMD) | | ADDRESS | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MULTIPLE ORGAN SYSTEM FAILURE 5609 DUE TO, OR AS A CONSEQUENCE OF (b) SEPTICEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) ACUTE LARGE BOWEL OBSTRUCTION | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CIRRHOSIS LIVER | | | | | | | | | | |
| 19a DATE OF OPERATION 3-26-81 | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED ACUTE LARGE BOWEL OSTR | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Leo A. Napier DEGREE | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 3-29-81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEO A. NAPIER, M.D. | | | | | | 22e. ADDRESS 206 BOW ST ELKTON MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | | 23b. DATE 3-30-81 | | 23c. NAME OF CEMETERY OR CREMATORY CRANTON & FORD'S | | 23d. LOCATION CITY OR TOWN COUNTY STATE Waste Hoston PH. | | | |
| 24. FUNERAL DIRECTOR NAME R. P. FORD | | | ADDRESS FUNERAL HOME | | | 25. DATE REC'D. BY REGISTRAR APR 3 1981 | | REGISTRAR'S SIGNATURE Anthony McBray | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires, that the death certificate be executed within 24 hours after death. Page 4 of 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



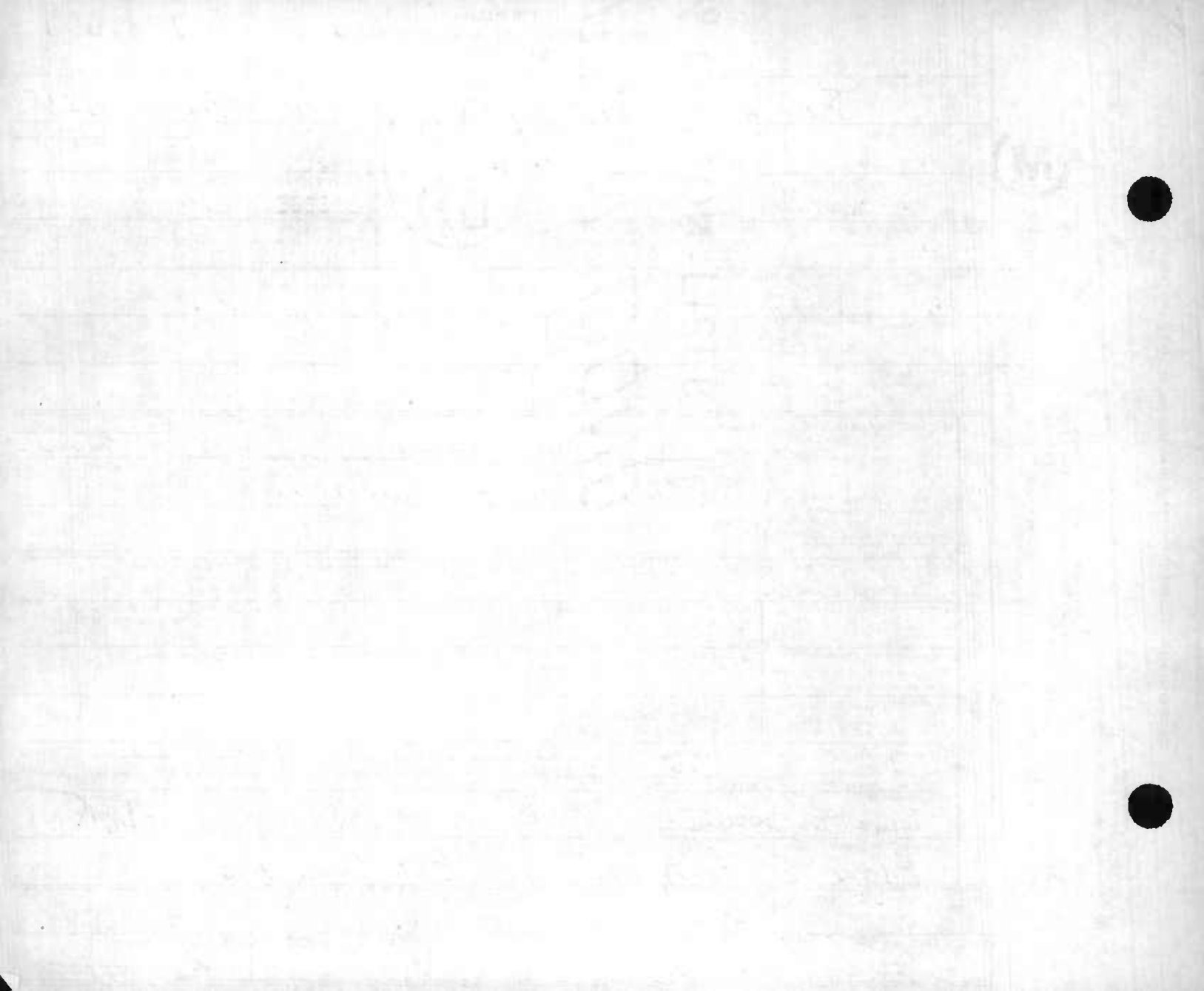
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 8 1 0 7 3 0 0 | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <u>JENNIE</u> <u>LEMINE</u> <u>LEMINEN</u> | | | | | 2a. DATE OF DEATH MONTH <u>3</u> DAY <u>16</u> YEAR <u>81</u> | | | 2b. HOUR <u>6:53</u> <u>A.</u> | |
| 3. SEX <u>Female</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH <u>Mar.</u> DAY <u>4</u> YEAR <u>1898</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>83</u> YRS. | | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>England</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Elkton</u> <u>Cecil</u> <u>MD.</u> | | | |
| 10. CITY OR TOWN OF DEATH <u>Elkton</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Union Hospital</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13a. STATE <u>Md.</u> | | 13b. COUNTY <u>Cecil</u> | | 13c. CITY OR TOWN <u>North East</u> | | 13e. STREET ADDRESS <u>6 Thomas Ave.</u> | | | |
| 14. FATHER'S NAME FIRST <u>No Info</u> MIDDLE <u></u> LAST <u></u> | | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>No Info</u> MIDDLE <u></u> LAST <u></u> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u> | | 16b. SOCIAL SECURITY NO. <u>192-22-9516</u> | | 17. INFORMANT ADDRESS <u>Helen M. Isaacs</u> <u>North East, Md.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>4/00</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypertension</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u></u> <u></u> <u></u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/15</u> 19 <u>81</u> to <u>3/16</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>3/16</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Edgar E. Zolner</u> <u>MD.</u> | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED <u>3/16/81</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Edgar E. Zolner III</u> | | | | | 22e. ADDRESS <u>Elkton, Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>3-19-81</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>North East Meth.</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>North East Cecil Md.</u> | | | |
| 24. FUNERAL DIRECTOR'S NAME <u>Paul Rouch</u> | | | | | 25a. DATE REC'D. BY REGISTRAR <u>3/16/81</u> | | | | |
| 25b. REGISTRAR'S SIGNATURE <u></u> | | | | | 25c. REGISTRAR'S SIGNATURE <u></u> | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | 8 1 0 7 3 0 1 CERTIFICATE OF DEATH | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST XXXX Samuel R. Logan | | | | | MONTH DAY YEAR HOUR 3/21/81 5:20A M | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| male | | caucasian | | MONTH DAY YEAR 11 18 07 | | 73 YRS. | | MONTHS DAYS HOURS MIN. | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 8b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Md. | | U.S.A. | | | | Cecil County MD. | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Elkton | | 2885 Singerly Rd. | | | | retired | | Construction | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | | | |
| 13b. STATE 13c. COUNTY 13c. CITY OR TOWN | | | | | YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| Md. Cecil Elkton | | | | | 2885 Singerly Rd. | | | | |
| 14 FATHER'S NAME | | | | | 15 MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST Charles A. Logan | | | | | FIRST MIDDLE LAST Blanche E. Henderson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | |
| XXXXXX No | | | | | 216-07-1837 | | Mrs. Kathleen J. Logan, Elkton, Md. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>1889</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma of Bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Richard Forlano M.D.</u> | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 3/21/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Forlano, M.D. | | | | | 22e. ADDRESS Singerly Rd. Elkton, Maryland 21921 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | 3/24/81 | | Union Cemetery | | Union Cecil Co. Md. | | |
| 24. FUNERAL DIRECTOR <u>Joseph E. Hicks</u> ADDRESS HICKS HOME FOR FUNERALS, ELKTON, MD. | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | | | MAR 26 1981 | | <u>Joseph E. Hicks</u> | |

10722

James H. Jones

Contractor

10722

Gold County

B. H. A.

10722

Central Connection

2952 Highway 10

10722

10722 Highway 10

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10722 Highway 10

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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 1 0 7 8 0 2 | |
|--|--|--|--|---|--|
| 1 - STATE REGISTRAR | | | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) JAMES W. McCANN | | | 2a DATE OF DEATH MONTH DAY YEAR 3/14/81 | | 2b HOUR 545 P. M |
| 3 SEX Male | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR May 25, 1913 | 6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | 7a UNDER 1 YEAR MONTHS DAYS HOURS MIN. 7b UNDER 24 HRS HOURS MIN. | |
| 8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD | | |
| 10 CITY OR TOWN OF DEATH Elkton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital | | 12a USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) Track Foreman | 12b KIND OF BUSINESS OR INDUSTRY Penna. RR | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13 STATE Delaware | | 13b CITY OR TOWN New Castle | 13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d STREET ADDRESS 870 Chambersrock Road | |
| 14 FATHER'S NAME William | | 15 MOTHER'S MAIDEN NAME Sadie | | 15 ADDRESS Unknown | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. 717-07-5547 | | 17 INFORMANT Vivian West, Newark Delaware 19711 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). 1629 HEPATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b). LUNG CANCER DUE TO, OR AS A CONSEQUENCE OF (c). | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (1) (this hospital) attended the deceased from 3/13 19 81, to 3/14 19 81, that (1) (we) lost saw the deceased alive on 3/14 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE Yogish A. Patel | | DEGREE MD | | 22c DATE SIGNED 3/18/81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Yogish A. Patel, M.D. | | 22e ADDRESS NEWARK, Del. | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE Mar. 19, 1981 | | 23c NAME OF CEMETERY OR CREMATORY Charlestown Cemetery, Cecil, Maryland | |
| 24 FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Maryland | | 24b ADDRESS | | 25a DATE RECD. BY REGISTRAR | |
| | | | | 25b REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| Item 14 8560 10/1/81 gj | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 1 0 7 8 0 3 |
|---|--|--|--|---|
| 1- FOR STATE REGISTRAR | | CERTIFICATE OF DEATH | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | 3 SEX | | 2a DATE OF DEATH |
| MARTHA L. McLAUGHLIN | | Female | | March 17, 1981 |
| 4 RACE | | 5. DATE OF BIRTH | | 2b. HOUR |
| White | | March 31, 1882 | | 5:50 P.M. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 6 AGE (IN YEARS LAST BIRTHDAY) |
| Maryland | | USA | | 98 YRS. |
| 7b CITIZEN OF WHAT COUNTRY? | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| USA | | Cecil County MD. | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |
| Elkton | | Union Hospital | | Housewife |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | |
| | | 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | |
| | | Maryland Harford Bel Air | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | |
| William H. Schaper | | Sarah Hynson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT |
| No | | 207-30-5784D | | Anna M. O'Bryan |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 5335 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Exacerbated peptic ulcer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Respiratory failure</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 3/8/81 Respiratory failure YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED |
| Vicente R. Carag, Jr. M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | Mar. 18, 1981 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | |
| Vicente R. Carag, Jr. M.D. | | 504 Lewis Street, Havre de Grace, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY |
| Burial | | Mar. 20, 1981 | | Slateville |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | Delta York Penna. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | 25. DATE RECEIVED BY REGISTRAR 26. REGISTRAR'S SIGNATURE | | |
| John H. Harkins, 600 Main Street, Delta, Penna. | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76
(VR A 15 (4))FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Margaret Tyson Mc Mullen | | | 2a. DATE OF DEATH MONTH 3 DAY 2 YEAR 81 | | | 2b. HOUR 7A | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH 9 DAY 4 YEAR 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | IF UNDER 24 HRS. HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil | | | | | |
| 10. CITY OR TOWN OF DEATH Rising Sun | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 20 Cherry St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | | 12b. KIND OF BUSINESS OR INDUSTRY Funeral Home | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY Cecil 13c. CITY OR TOWN Rising Sun | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 20 Cherry St. | | | |
| 14. FATHER'S NAME FIRST John MIDDLE Earl LAST Tyson | | | 15. MOTHER'S MAIDEN NAME FIRST Ella MIDDLE Tosh LAST Tosh | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 220-22-0563 | | | 17. INFORMANT Vernon E. McMullen | | | ADDRESS Same Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) coronary insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) 1 yr. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH four hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-15 , 19 80 , to 3-2 , 19 81 , that (I) (we) last saw the deceased alive on 3-1 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Neil Taylor | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 3-2-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor MD | | | | | | 22e. ADDRESS Rising Sun, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 3-5-81 | | | 23c. NAME OF CEMETERY OR CREMATORY West Nottingham | | | 23d. LOCATION CITY OR TOWN Cecil COUNTY Cecil STATE MD. | | |
| 24. FUNERAL DIRECTOR NAME Vernon E. McMullen ADDRESS Rising Sun, MD | | | | | | 25. DATE REC'D. BY REGISTRAR MAR 6 1981 | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | |



12-28

SM

Items #10a-22a Film G555 5/8/81 re STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

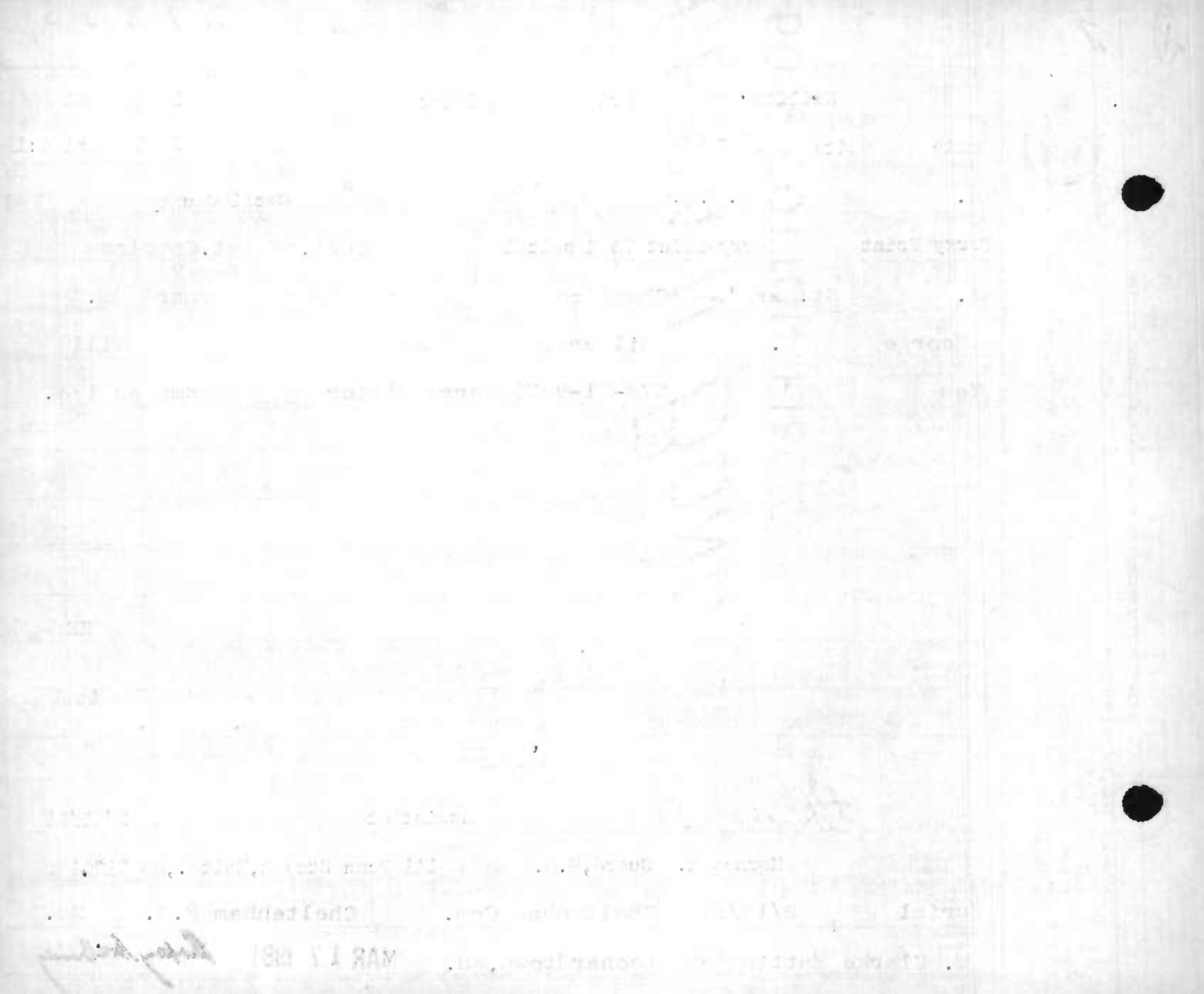
| | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|-----------------------------------|--|---|--|--------------------------|--|---|--|------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| William Earl Miller | | | | | | | | 3 10 19 81 | | | | | | | | 4:15 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| male | white | 2-11-18 | | 63 YRS. | | | | | | 3 10 19 81 | | | | | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Pa. | | U.S.A. | | | | | | | | | | Cecil County | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Perry Point | | Perry Point VA Hospital | | Cust. of Apt. Complex | | | | | | | | | | | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | | | | | | | |
| Md. | | St. Mary's Chaptico | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Box 76 Hurry & Dynard Rd. | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| George W. Miller | | Emma Mill | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| Yes | | WW2 | | 578-01-9975 | | Harry Miller | | Same as 13e. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Desipramine intoxication</u> 9503 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Est. HOUR A.M. MONTH DAY YEAR ? P.M. 3/10/19 81 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self ingested | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) unknown | | | | 21f. LOCATION Found in pool Perry Point Hospital Perry Point Cecil Co. Md. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>H.R. Swaid</u> | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 3/11/81 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 3/13/81 | | | | 23c. NAME OF CEMETERY OR CREMATORY Cheltenham Cem. | | | | 23d. LOCATION CITY OR TOWN Cheltenham P.G. COUNTY Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME W. Clarke Mattingley | | | | ADDRESS Leonardtown, Md. | | | | 25a. DATE REC'D. BY REGISTRAR MAR 17 1981 | | | | 25b. REGISTRAR'S SIGNATURE <u>Harry Mattingley</u> | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

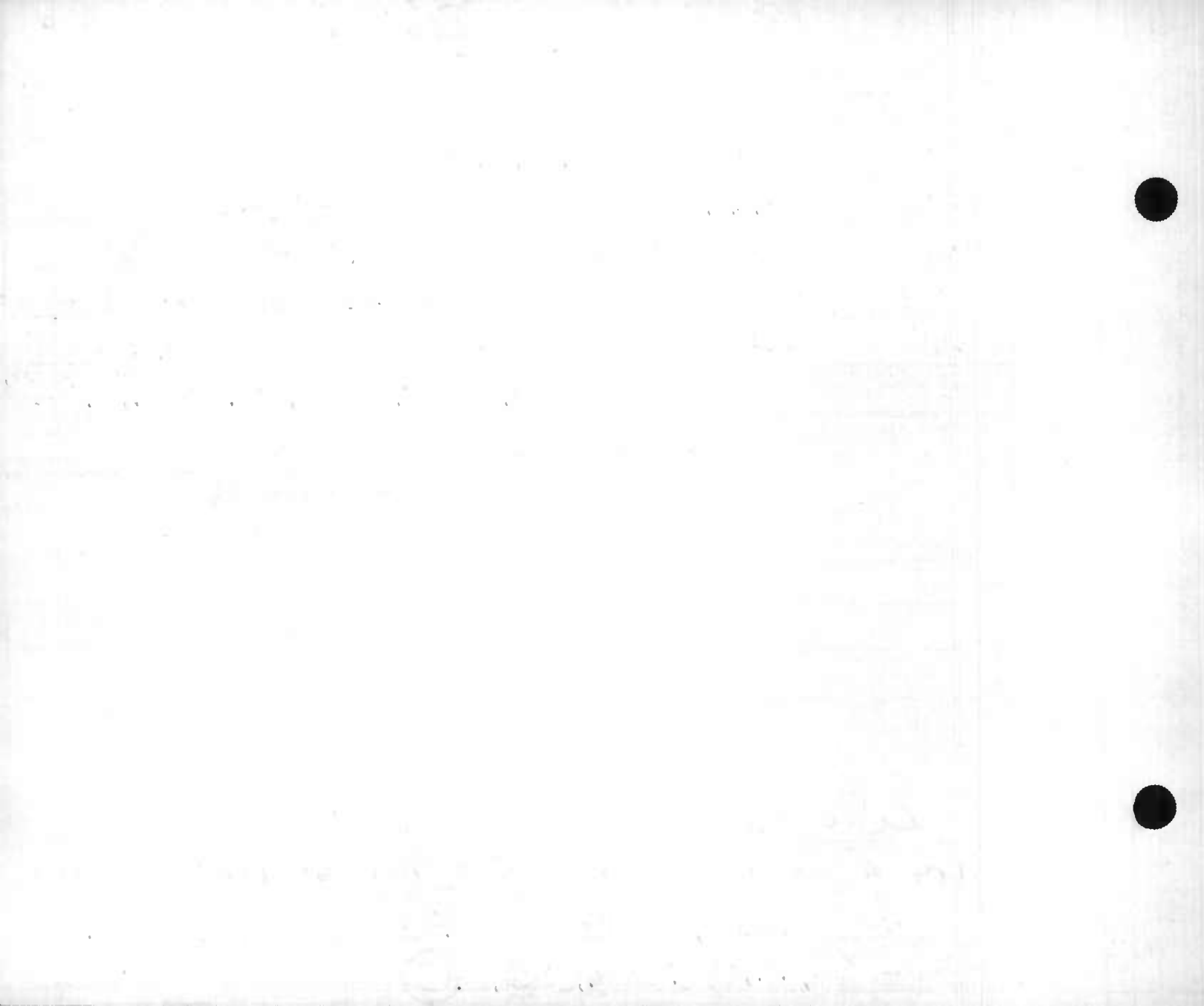
8107806

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Jacob T. Minster | | | 2a. DATE OF DEATH MONTH 3 / DAY 12 / YEAR 81 | | | 2b. HOUR 1045 AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH Aug. / DAY 13 / YEAR 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH. Cecil County MD. | |
| 10. CITY OR TOWN OF DEATH Elkton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Photographer | | 12b. KIND OF BUSINESS OR INDUSTRY Phot | |
| 13a. STATE Maryland | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Elkton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST John MIDDLE Jacob LAST Minster | | 15. MOTHER'S MAIDEN NAME FIRST Emma MIDDLE Swartz LAST Swartz | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-12-4350 | | 17. INFORMANT ADDRESS Harvey Cedars, Mr. Edgar A. Hathaway, 15 W. 80th St., N. Jersey. | | | |

| | | | | | |
|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1530 IMMEDIATE CAUSE (a) HYPOSTATIC PNEUMONIA | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) MACNUTRITION, CARCINOMATOSIS | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) CA FRACTURE, CARCINOMATOSIS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 3/4 , 19 81 , to 3/12 , 19 81 , that (1) (we) lost saw the deceased alive on 3/12 , 19 81 , and that in (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Leo A. Napolitano | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leo A. Napolitano | | | | 22e. ADDRESS 206 Bow St Elkton Md | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE March 16, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Park | |
| 23d. LOCATION CITY OR TOWN Elkton | | 23e. COUNTY Cecil | | 23f. STATE Md. | |
| 24. FUNERAL DIRECTOR NAME See Funeral Home ADDRESS 111 E. Main St., Elkton, Md. | | | | 25. DATE REC'D. BY REGISTRAR MAR 18 1981 | |
| | | | | 26. REGISTRAR'S SIGNATURE [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

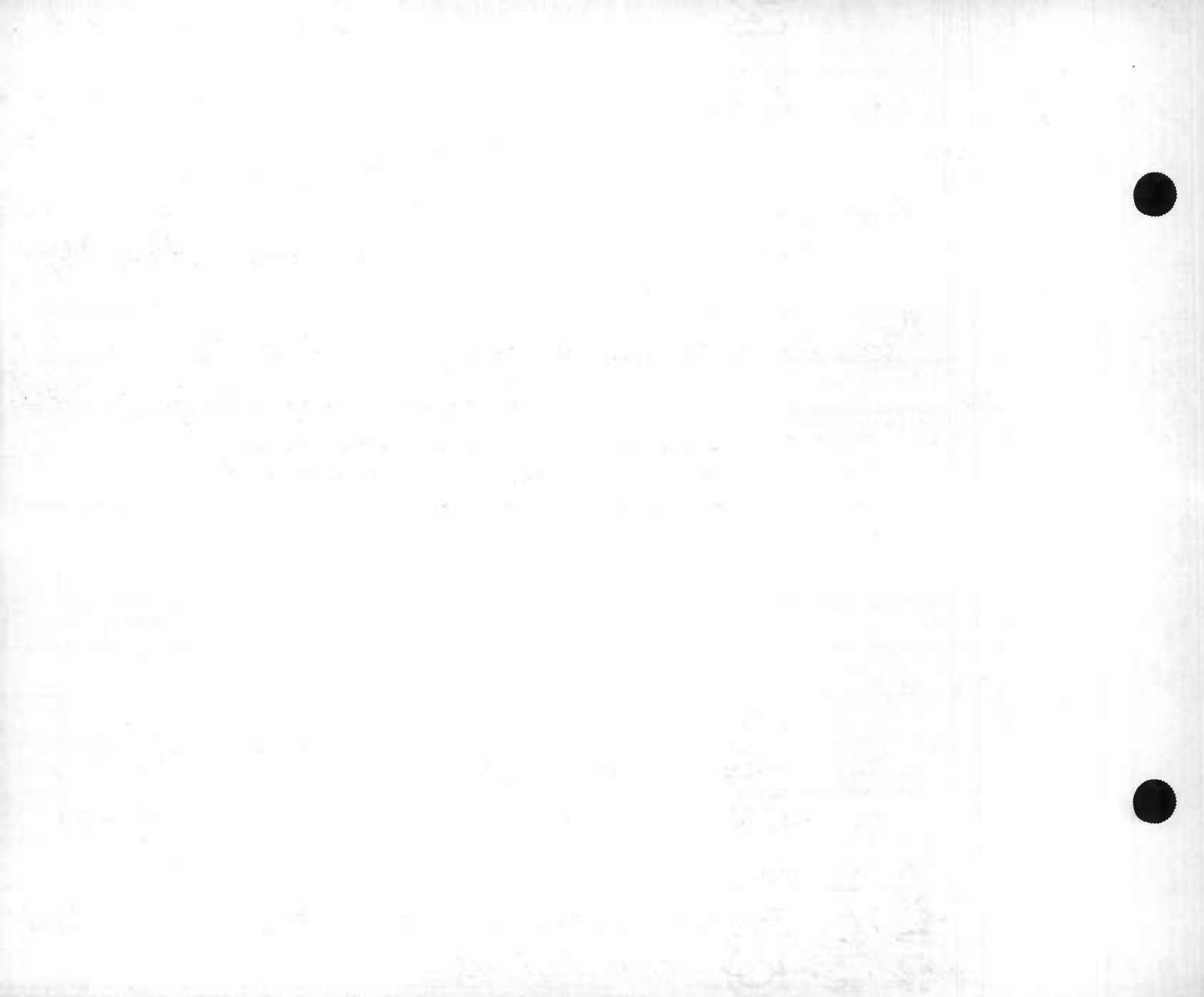
Item 18a 3554 4/9/81 dad

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 07807

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Edna Ruth Patton | | 2a. DATE OF DEATH MONTH DAY YEAR 3-20-81 | | 2b. HOUR 4:10 P.M. | |
| 3. SEX Female | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR 9/5/18 | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | 7c. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | | |
| 10. CITY OR TOWN OF DEATH Elkton, Md. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Home of Cecil County | 12a. USUAL OCCUPATION (THREE OF WORK FOR MOST OF WORKING LIFE) Supervisor | 12b. KIND OF BUSINESS OR INDUSTRY Alum Mfg. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY Cecil | 13c. CITY OR TOWN North East | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 208 Lakeside Drive |
| 14. FATHER'S NAME FIRST MIDDLE LAST Treeley M. Richardson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Prizette | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 242-05-9807 | | 17. INFORMANT ADDRESS Shirley B. Bradley North East, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). Metastatic papillary adenocarcinoma. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma from ovary</u> 1830 DUE TO, OR AS A CONSEQUENCE OF (b) <u>from ovary with ascitis and pleural effusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from _____, 19____, to <u>3/20</u> , 19 <u>81</u> , that (1) (we) lost saw the deceased alive on <u>3/20</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Jui-chih Hsu | | DEGREE M.D. | | 22c. DATE SIGNED 3/20/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joi Chih Hsu | | 22e. ADDRESS 223 West main st. sec. 142 21921 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3-24-81 | | 23c. NAME OF CEMETERY OR CREMATORY North East Meth | |
| 23d. LOCATION CITY OR TOWN North East | | 23e. COUNTY Cecil | | 23f. STATE Md. | |
| 24. FUNERAL DIRECTOR NAME Charles Crouch | | ADDRESS North East Md. | | 25a. DATE REC'D BY REGISTRAR MAR 21 1981 | |


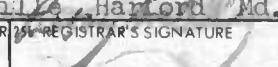
BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician or page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 1 0 7 8 0 8 | | | |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Fred Stahl Rees | | | | 2b. HOUR 7:55P M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7 16 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 60 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD | |
| 10. CITY OR TOWN OF DEATH Perry Point | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Veterans Admin. Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Havre de Grace | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie I. Snyder | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW-II | | | |
| 16a. SOCIAL SECURITY NO. 187 12 8114 | | 17. INFORMANT ADDRESS VAMC, Perry Point, Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4379 IMMEDIATE CAUSE (a) Cardio Respiratory Arrest second degree DUE TO, OR AS A CONSEQUENCE OF (b) to cerebrovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-14- 1978 , to 3-25- 1981 , that X (we) lost saw the deceased alive on 3-25-1981 , and that in xx (our) opinion death occurred on the date and hour and from the causes stated above, xx (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE  | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 3-25-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. JACQUES JEAN-PIERRE, M.D. | | 22e. ADDRESS VAMC, Perry Point, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3/28/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Calvary Methodist | | 23d. LOCATION CITY OR TOWN COUNTY STATE Churchville Harford Md. | |
| 24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A. Aberdeen, Md. 21001 | | | | 25. DATE REC'D. BY REGISTRAR MAR 30 1981 | | 26. REGISTRAR'S SIGNATURE  | |



Fred Stahl News

March 22, 1981

7:55p

Is the 1980 V 16 1980

X

X

187 12 8114 VANC, Perry Point, MD

Cardio Respiratory Arrest second degree

to cerebrovascular disease

3-25-81 78 2-14-

81

F. JACQUES JEAN-PIERRE, M.D. VANC, Perry Point, MD.

BP

DHMH-16 50M 7/77
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 1 0 7 8 0 9

| | | | | | | |
|--|--|---|---|---|---------------------------|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHRISTIAN FREDERICK REUTER | | | 2a DATE OF DEATH MONTH DAY YEAR March 18, 1981 | | 2b HOUR 10:20am | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10 2 1907 | | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | |
| 10. CITY OR TOWN OF DEATH Perry Point | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center | | 9 BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD. | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postman | | | 12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Dundalk | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST August L. Reuter | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine M. Burnett | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 218-01-1564 | | 17 INFORMANT ADDRESS Helen M. Reuter same as 13e. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1469 IMMEDIATE CAUSE (a) Cardiac arrest and bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of the oropharynx w/lung metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that X (this hospital) attended the deceased from March 13 , 19 81 , to March 18 , 19 81 , xxxxxxx and that in (my) (our) opinion death occurred on the date and hour and from the causes stated I have viewed the body after death. | | | | | | |
| 22b. SIGNATURE Joaquin R. Garcia M.D. | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 3-18-81 | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) J. R. GARCIA, M.D. | | 23b. ADDRESS VAMC, Perry Point, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 3/20/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | 24. FUNERAL DIRECTOR NAME ADDRESS Brooks Bradley Funeral Home, Dundalk, Md. | | 25a. DATE REC'D. BY REGISTRAR MAR 20 1981 | | |
| 25b. REGISTRAR'S SIGNATURE Dorothy McCreedy | | | | | | |

MEDICAL CERTIFICATION

2
9
1

Form with multiple sections and fields, including a header area with a date field (10-10-61) and a title field (10-10-61). The form contains several rows of data, some of which are partially obscured by a large, faint, circular stamp or watermark. The text is mostly illegible due to the quality of the scan.

Item 50 554 4114/81 GB

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ruth M. Root | | | 2a. DATE OF DEATH MONTH DAY YEAR March 30, 1981 | | | 2b. HOUR 12:15A M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 22, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Elk Township, Pa. | | 9. CITIZEN OF WHAT COUNTRY? U.S. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | | | |
| 12. CITY OR TOWN OF DEATH Rising Sun | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home, Inc. | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Packer | | 15. KIND OF BUSINESS OR INDUSTRY Candy | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 17a. STATE PA | | 17b. COUNTY Chester | | 17c. CITY OR TOWN Oxford | | 17d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 17e. STREET ADDRESS 417 Lincoln St. | |
| 18. FATHER'S NAME FIRST MIDDLE LAST Theodore Barrett | | | | 19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Sheline | | | | | |
| 20a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 20b. SOCIAL SECURITY NO. MA456396 | | 20c. INFORMANT ADDRESS Mrs. Ruth Ann Roney, 403 Mount Olive Rd. Oxford, Pa. 19363 | | | |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 22. MEDICAL CERTIFICATION | | | | | | | | | |
| 22a. DATE OF OPERATION | | 22b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 22c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 22e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 22f. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 22g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 22h. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 22i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 22j. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22k. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22l. SIGNATURE <u>G.T. HOLCOMBE</u> | | | | 22m. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22n. DATE SIGNED 3-30-81 | |
| 22o. PHYSICIAN'S NAME (TYPE OR PRINT) G.T. HOLCOMBE | | | | 22p. ADDRESS OXFORD, PA 15363 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Apr. 1, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Ground Brick Meeting House B. | | 23d. LOCATION CITY OR TOWN Calvert | | 23e. COUNTY STATE Cecil Md. | |
| 24. FUNERAL DIRECTOR NAME Richard L. Goodie | | | | 24b. ADDRESS Rising Sun | | 24c. DATE REC'D. BY REGISTRAR APR 3 1981 | | 24d. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

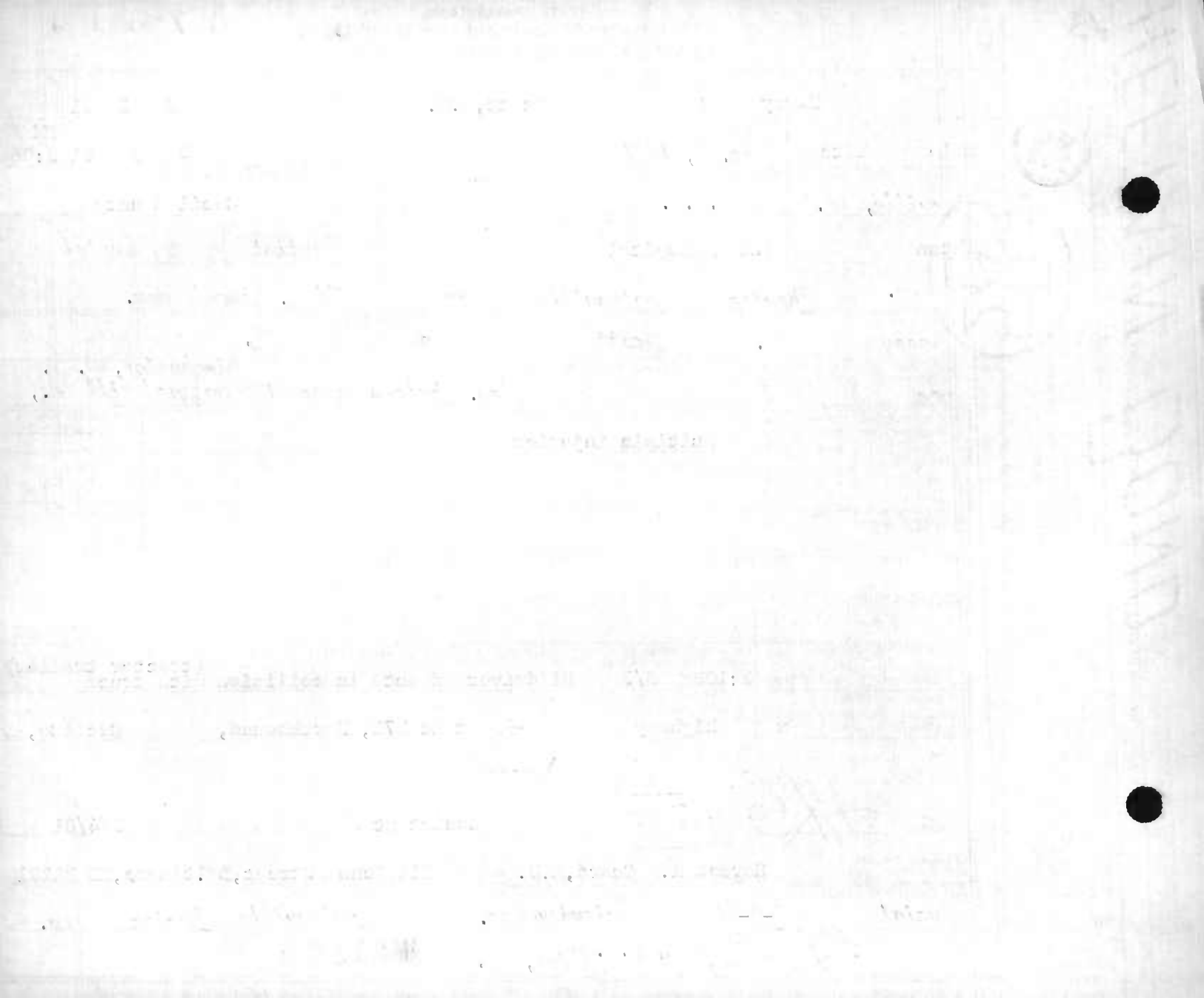
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

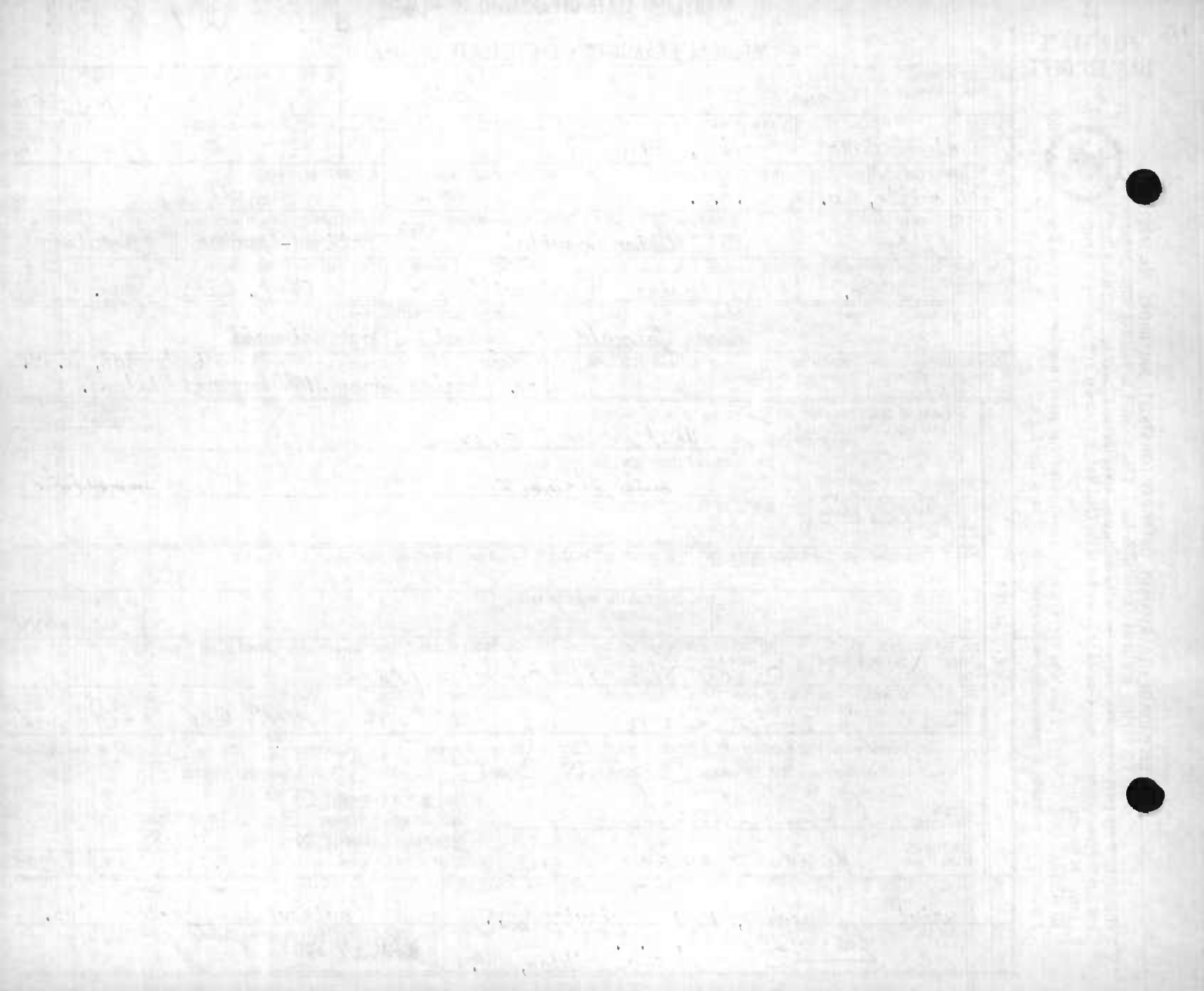
| | | | | | | | |
|--|-------------------------|---|---|---|--|--|--|
| 1. DECEASED-NAME (Type or Print) First Middle Last <i>Jone Scott</i> | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year MATED <input type="checkbox"/> 3/ 3/ 81 | | | 2b. HOUR 2:00 PM | |
| 3. SEX <i>Female</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH <i>April 5, 1911</i> | 6. AGE (In years last birthday) <i>69</i> YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN | 2c. DATE PRONOUNCED DEAD Month Day Year <i>3 1 3 1 81</i> | |
| 7a. BIRTHPLACE (State or foreign country) <i>Coatesville, Pa.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Cecil</i> Md. | |
| 10. CITY OR TOWN OF DEATH <i>Elkton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Union Hospital</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <i>Retired Teacher</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Education</i> |
| 13a. USUAL RESIDENCE (Where deceased lived at admission) STATE <i>Pa.</i> | | 13b. COUNTY <i>Chester</i> | | 13c. CITY OR TOWN <i>Coatesville</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last <i>Guy Brown Griswold</i> | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Janet Doan Griswold</i> | | 13e. STREET AND NUMBER <i>544 E. Lincoln Hwy.</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | | 16b. SOCIAL SECURITY NO. <i>8129</i> | | 17. INFORMANT ADDRESS <i>Mrs. Charles Bowen 2194 Hazzard Hill Rd. Binghamton, N. Y.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Head & Chest trauma</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Auto Accident</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>last.</i> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year <i>2:10 P.M. 3/3 1981</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) <i>Auto hit a truck</i> | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>I-95 at rd 272</i> | | 21f. LOCATION Street or R.F.D. No. <i>I-95 @ rd 272</i> | | City or Town County State <i>North East, Cecil Md.</i> | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <i>Henry Farkas</i> | | EXAMINER'S NAME (Type) <i>Henry Farkas, MD</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <i>3/3/81</i> | |
| ADDRESS (Street, city, town, or county) <i>Elkton, Md. ~1921</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>March 9, 1981</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Fairview Cem.</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Coatesville Chester Pa.</i> | |
| 24. FUNERAL DIRECTOR <i>See Funeral Home</i> | | | | 25a. REC'D BY REGISTRAR <i>MAR 12 1981</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours

after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH NECESSARY RECORDS, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07813 | |
|--|------------------|---|--|--|---|---|---|--|----------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert William Sherk | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 15 1981 | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 12/21/59 | | 6. AGE (IN YEARS LAST BIRTHDAY) 21 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 3 16 1981 | | 2b. HOUR 4:30 P M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County, MD. | | | | |
| 10. CITY OR TOWN OF DEATH Elkton | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student | | 12b. KIND OF BUSINESS OR INDUSTRY College | | | |
| 13a. STATE Md. | | 13b. CITY OR TOWN Balto. | | 13c. CITY OR TOWN Perry Hall | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 9533 Bauer Ave. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward R. Sherk | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nadene V. Darr | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 212-78-0387 | | 17. INFORMANT ADDRESS Edward Sherk (father) same address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Carbon Monoxide Intoxication</u> 9520 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY ESTIMATED HOUR A.M. MONTH DAY YEAR ? P.M. 3 15 1981 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject inhaled exhaust fumes from van | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadside | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 222 & Octoraro Creek, Conowingo, Cecil, Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Virginia L. Dolan</u> | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 3/17/81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE 3/21/81 | | 23c. NAME OF CEMETERY OR CREMATORY Greenmount | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | | |
| 24. FUNERAL DIRECTOR SCHIMONEK FUNERAL HOME, INC. | | | | | | ADDRESS 9705 Belair Rd. Balto. Md. 21236 | | 25a. DATE REC'D. BY REGISTRAR MAR 20 1981 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

34

Handwritten signature

MAR 5 1961

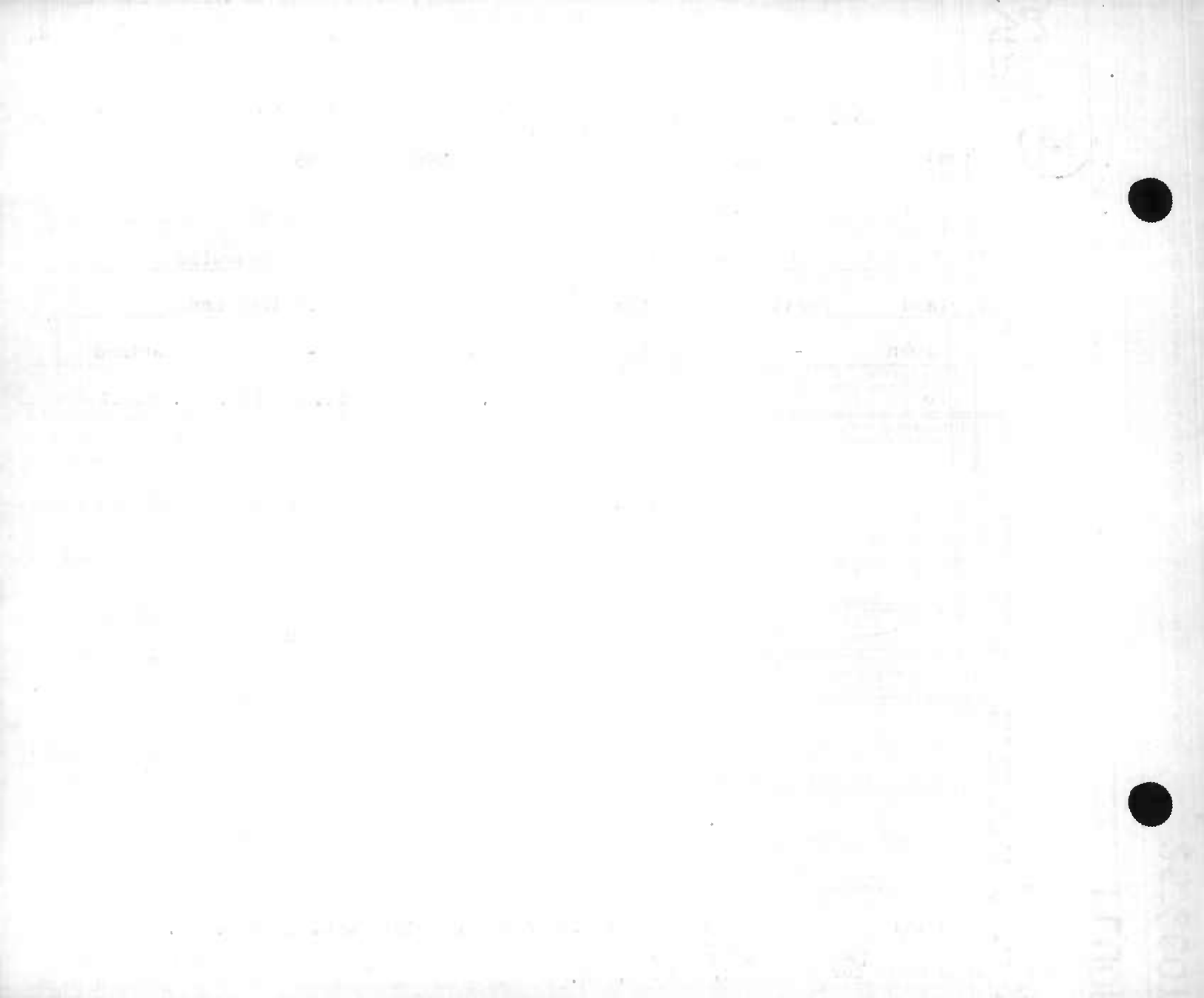
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of on

| FOR 1 - STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 0 7 8 1 4 | | | |
|--|--|--|--|--|--|---|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) | | | | 2a DATE OF DEATH | | | | 2b HOUR | | | |
| Nora E. Slagle | | | | 3/29/81 | | | | 4:05 P.M. | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | White | | 3 17 1896 | | 85 YRS. | | MONTHS | | DAYS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| N.C. | | USA | | | | Cecil MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Elkton | | Union Hospital of Cecil County | | | | | | Housewife | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b CITY OR TOWN | | | | 13c INSIDE CITY LIMITS? | | | |
| Maryland | | | | Cecil | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14 FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 13a. STREET ADDRESS | | | |
| John - Canipe | | | | Mary - Garland | | | | 80 Carriage Lane | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b SOCIAL SECURITY NO. | | | | 17 INFORMANT ADDRESS | | | |
| No | | | | | | | | Mrs. Mary Barnett, Elkton, Md. 21921 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY. | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardio respiratory arrest | | | | | | | | | | | |
| 4409 DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Arteriosclerotic disease | | | | | | | | | | many years | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Pneumonia | | | | | | | | | | several weeks | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| NONE | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | P.M. 19 | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | | | |
| 22 I certify that (I) (this hospital) attended the deceased from 3/24 19 81 to 3/29 19 81, that (I) (we) last saw the deceased alive on 3/29 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22a SIGNATURE Vincent Brandeis, MD | | | | | | | | DEGREE | | 22c DATE SIGNED | |
| | | | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 3/29/81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Brandeis | | | | | | | | 22e ADDRESS Elkton Hospital | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 4/1/81 | | Gilpin Manor Memorial Park, Elkton, Md. | | | | | |
| 24 FUNERAL DIRECTOR NAME Donald S. Hicks | | | | | | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| HICKS HOME for FUNERALS, ELKTON, MD. | | | | | | | | APR 6 1981 | | [Signature] | |

BP

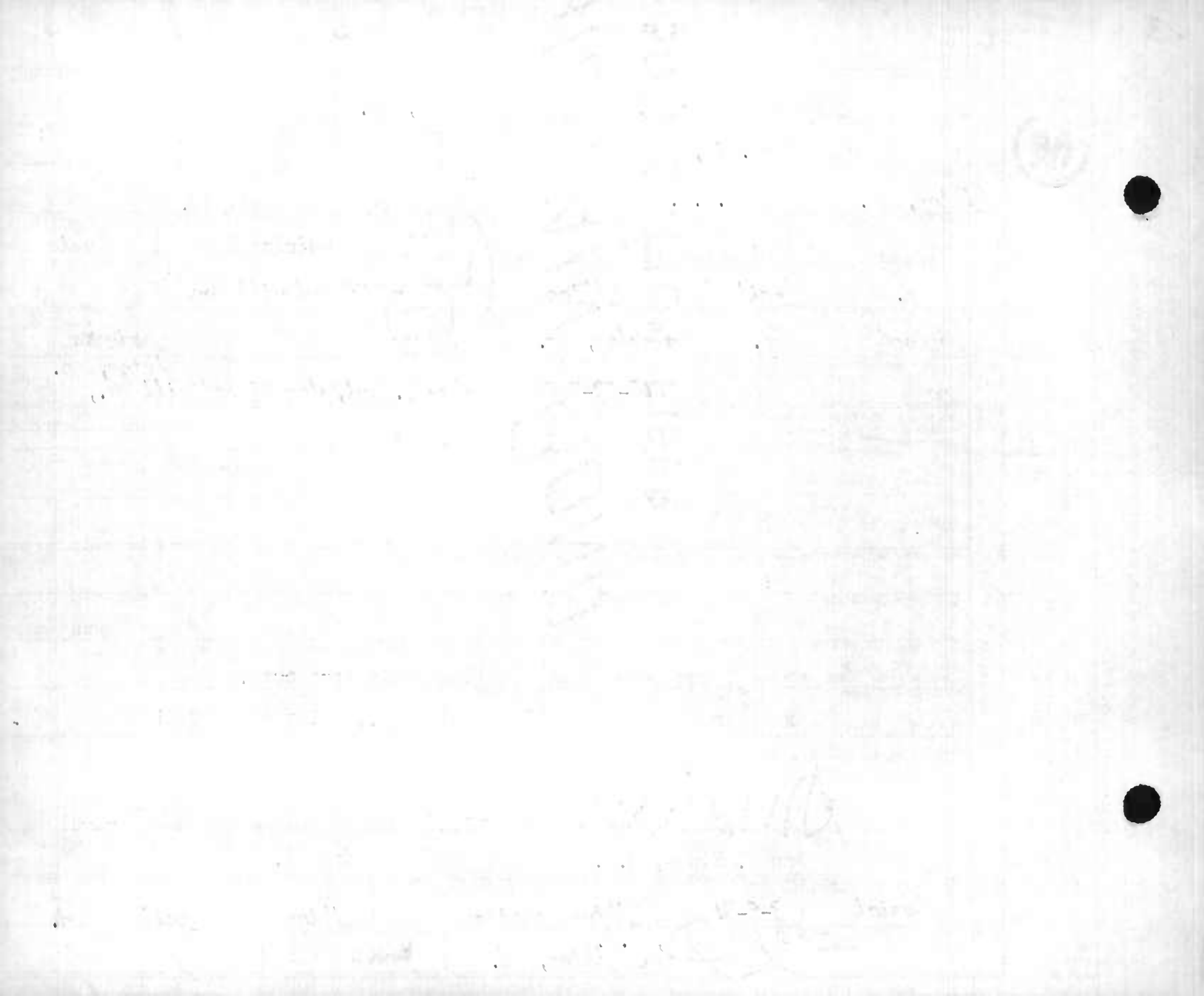


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 07815 | |
|---|--|---|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND A. WALMSLEY, Jr. | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 3 2 1981 | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH (MONTH DAY YEAR) Apr. 10, 1950 | | 6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 2 1981 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Elkton, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. | | | | 2b. HOUR 7:14 a.m. | |
| 10. CITY OR TOWN OF DEATH Elkton | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital (DOA) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Musician | | 12b. KIND OF BUSINESS OR INDUSTRY Music | | | |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Elkton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 95 Red Hill Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Raymond A. Walmsley, Sr. | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laurd Goodyear | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 212-52-7258 | | 17. INFORMANT Debra J. Walmsley | | ADDRESS 95 Red Hill Rd., Elkton, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon monoxide intoxication</u> 9820 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? xxx 3-2- 19 81 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Inhaled fumes from auto. | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) auto | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 95 Red Hill Rd., Elkton Cecil Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <u>Undetermined manner</u> <input checked="" type="checkbox"/> . <u>Accident</u> <input type="checkbox"/> . <u>Suicide</u> <input type="checkbox"/> . <u>Homicide</u> <input type="checkbox"/> . <u>Undetermined manner</u> <input checked="" type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 3-2-81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 3-5-81 | | 23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Elkton Cecil Md. | | | |
| 24. FUNERAL DIRECTOR NAME P.A. Elkton, Md. | | | | 25a. DATE REC'D. BY REGISTRAR MAR 6 1981 | | 25b. REGISTRAR'S SIGNATURE | | | | | |



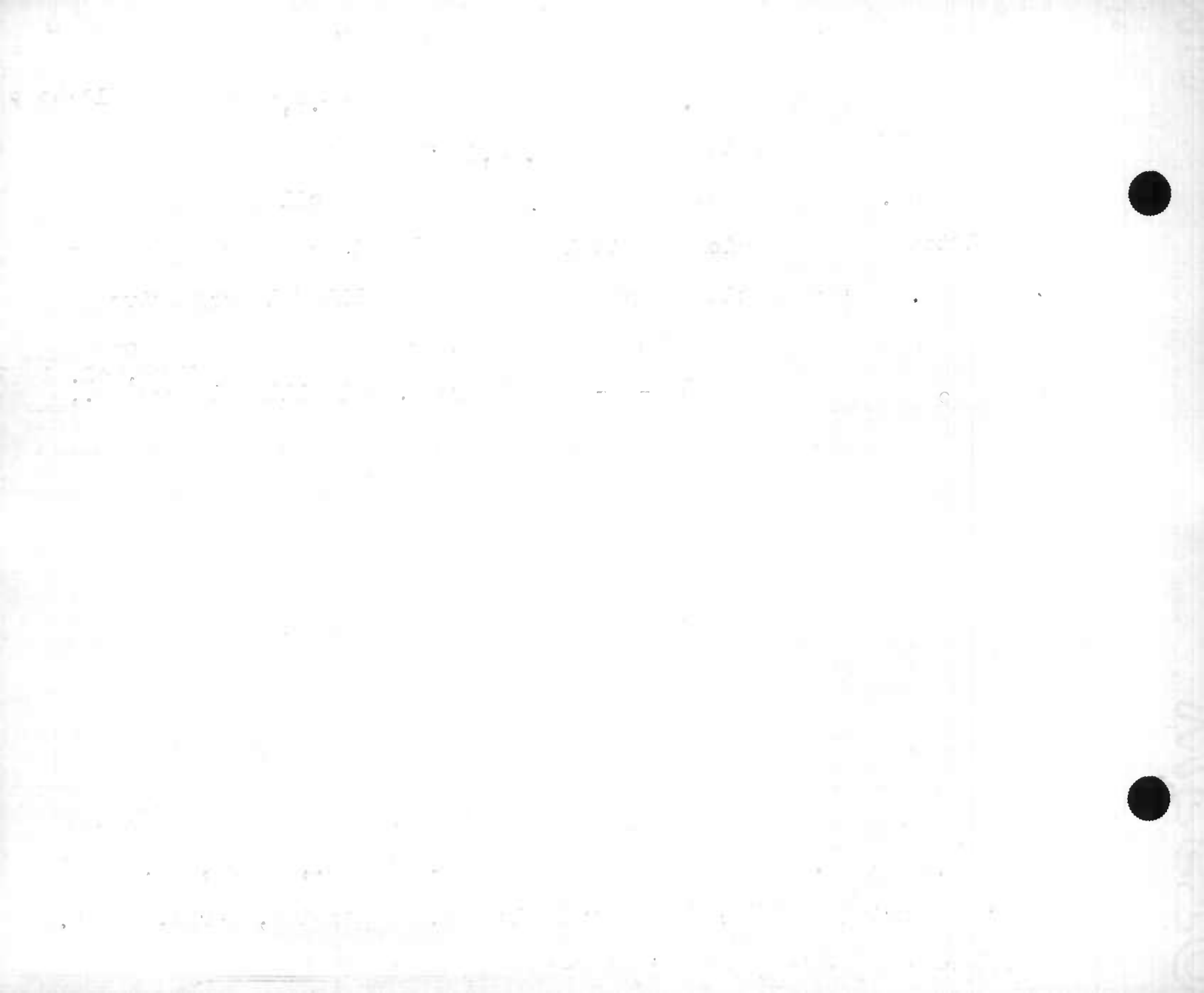
3
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | |
|--|--|---|-------------------|--|--|--|--|--|-----------------------------------|--|------------|--|
| 1. FOR STATE REGISTRAR | | 7. REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | 2b. HOUR | |
| PAUL G. YOCOM | | | | | | Mar. 9, 1981 | | | | | 11:43 AM P | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Male | | White | | Sept. 10, 1887 | | 93 YRS | | MONTHS DAYS | | HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Penna. | | USA | | | | Cecil MD | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Elkton | | Union Hospital | | | | Cigar maker | | | Tobacco | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE | | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | |
| Del. | | | | New Castle | | Newark | | 111 Mulberry Drive | | | | |
| 14 FATHER'S NAME | | | | 15 MOTHER'S MAIDEN NAME | | | | | | | | |
| John Yocom | | | | Laura Good | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT | | ADDRESS | | | | | | |
| No | | 170-07-4488 | | Gladys S. Peel | | Newark, Del. 19711 111 Mulberry Dr., | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - and</u> 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>congestive heart failure</u> (c) <u>coronary disease</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/28</u> 19 <u>78</u> , to <u>3/9</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>3/9</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | | | | |
| James R. Dearworth MD | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 3/10/81 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | | |
| James R. Dearworth MD | | | | | | 167 W. Main St., Newark, Del. 19711 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | |
| Burial | | 3/12/81 | | Laureldale Cem. | | Reading, Berks, Penna. | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | DATE REC'D. BY REGISTRAR | | | | | | |
| Robert T. Jones, Newark, Del. | | | | | | 3/10/81 | | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 1 0 7 8 1 7 | | | | | |
|---|--|---|--|---|--|--|--|--|--|---|--|--------------------------------|--|-----------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Hoecence D. ZASS | | | | March | | | | 12 | | 81 | | 11 | | 10 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | White | | July 21, 1886 | | | | 94 | | | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| New York | | USA | | | | | | Cecil | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Elkton | | Union Hospital | | | | Housewife | | | | | | | | | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | | | 13c. INSIDE CITY LIMITS? | | | | 13d. STREET ADDRESS | | | |
| Delaware | | | | New Castle | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 106 Delrem Drive | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Henry Volmer | | | | Sarah | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO | | | | 17. INFORMANT | | | | ADDRESS | | | |
| No | | | | 221-50-6274 | | | | Dorothy Z. Christman | | | | Newark, Del. 106 Delrem Dr. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, STOMACH</u> <u>1519</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 3/9/81 | | | | CARCINOMA, STOMACH | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/12/81</u> to <u>3/12/81</u> , that (I) (we) lost saw the deceased alive on <u>3/12/81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | 22b. SIGNATURE <u>John A. Fischer</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>3/12/81</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | | | |
| John A. Fischer | | | | ELKTON, MARYLAND | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | | 3/16/81 | | Pomfret Manor | | | | Sunbury, Northumberland, Pa. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert T. [Signature] | | | | Newark, Del. | | | | MAR 18 1981 | | | | [Signature] | | | |

